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THE UNIVERSITY OF ALBERTA

# EXPERIENCING DIFFICULTY IN PSYCHOTHERAPY: AN INTERPRETATIVE STUDY

by

HOWARD Y. LEIBOVITCH

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

IN

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Experiencing Difficulty in Psychotherapy: An Interpretative Study submitted by Howard Yehuda Leibovitch in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Counselling Psychology.

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Date: July 31, 1987

## Dedication

I dedicate this thesis to my wife, Tova, and to my children, Ayelet and Avigail who faithfully stood by me and supported me throughout this project and my years in school. Let us together move forward through love and compassion. I also welcome Yael Meira to our family, who already has been a source of strength and love.

## ABSTRACT

The study arose out of an interest in the concept of psychotherapeutic resistance. A review of the literature on resistance indicated a divergence of views about what resistance is, where it lies, and how to deal with it. Views were generally subordinate to the larger theoretical contexts the author subscribed to. Lacking in the literature were descriptions pertaining to meaning of the experience as lived and remembered by the therapist. This investigation was designed to gather such descriptions and to interpret them.

Participants in the study were active therapists with at least five years of post-graduate clinical experience in various public and private settings. The data base was generated through open-ended research questions where participants were asked to describe an experience of ongoing difficulty in a psychotherapeutic situation. This was followed by individual interrogations in which further elaborations of what was produced in the original protocols were pursued. An interpretative method was utilized for identifying general and unique themes of the experience.

The descriptions revealed that common to participants were feelings of being frustrated, angry and helpless, of uncertainty about how to proceed, of being ineffective and of these situations as being extreme. Unique meanings included experiences of space being violated, of the situation as being unnatural, of the situation as challenging and stimulating, of having non-typical bodily experiences and of an awareness of larger system contributions.

A number of the characteristics were interpreted in the discussion. Particular difficulty was viewed as non-typical in contrast to what the author viewed as how typical therapy situations are experienced. Therapists' orientations and work settings affected whether or not the therapist was overpowered by his/her own affect. Questions such as whether therapists experienced a passion for change and whether feelings of uncertainty about how to proceed led to reflective thought regarding one's orientation were raised and discussed. Arising from this study, a perspective for understanding resistance as traditionally conceptualized was also offered.

## Acknowledgements

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# 1. INTRODUCTION

## 1.1 Difficulty in Psychotherapy

Probably, all psychotherapists at one time or another have experienced difficulty with their psychotherapeutic encounters. As students and therapists-in-training, difficulties may be shared with a supervisor. As professionals in the field, we may share the difficulties we are experiencing with colleagues or paid consultants. Often we will make statements like "she drove me nuts" or "I was so totally frustrated with the couple I wanted to throw them out of my office".

Rarely do therapists go beyond these kinds of basic statements to examine how they actually experienced the situation and how, as participants in the therapy project, they co-constitute that which was experienced. What often occurs is a shift to a level where the therapist and supervisor attempt to make sense of a difficult experience and try to come up with appropriate interventions or explanations for resolving the difficulty. Fessler (1983) described probable implications of this process in reference to novice therapists:

> But rather than clarifying what he is doing, these efforts to make sense may be distancing him from

> his own lived experience. He may be unwittingly smoothing over important aspects of the psychotherapeutic process, constructing an abstract conceptualization of it that is neater and more attuned to the traditional understanding of what should be taking place. To the degree that he is successful, he may gradually lose sight of those experiences that slip through this conceptual mesh. (p. 39).

The experiencing statements are secondary to the cognitive evaluation of the process these statements reflect. Even when explicitly expressed, one's experience is typically subordinated to a theoretical perspective and dealt with in a cognitive manner (e.g. through such concepts as countertransference, client compliance and noncompliance). Therapist experiencing remains in the realm of the unexamined pre-reflective, unexplicated and unexplained. Emotional, bodily, cognitive, cultural and social dimensions remain obscure as we go about the task of explaining. In placing an understanding of experiencing difficulty in psychotherapy in a secondary position we may be depriving ourselves of grasping important aspects of what it means to be a psychotherapist as well as gaining a fuller appreciation of the richness and complexities of one's experiences. This study proposed to utilize participant descriptions for revealing different characteristics contributors attributed to their experiences of particular difficulty.

## 1.2 Difficulty in Psychotherapy and Psychotherapeutic Resistance

When therapists refer to difficulty in therapy, they frequently write and speak about it in terms of their understanding of client or family resistance. (Basch, 1982; Breit, Wen-Gim and Wilner, 1984; Dewald, 1982; Fay and Lazarus, 1982a; Fay and Lazarus, 1982b; Jahn and Lichstein, 1980;...).

Generally, understanding is subordinated to the larger theoretical context to which the therapist subscribes. A psychodynamic psychotherapist will understand resistance in terms of the writings of Freud and neo-Freudians. A Cognitive-Behavioural therapist comprehends resistance in a manner consistent with conceptualizations in the Cognitive-Behavioural literature. A family therapist's understanding of resistance fits the way or ways of the particular school of Family Therapy which the therapist follows.

Rather than being anchored to an understanding of difficulty as actually experienced, the literature on psychotherapeutic resistance was based on theoretical models and hypotheses grounded in thought. These models and hypotheses assume that for research to be systematic and rigorous, it will be necessary to employ

experimental methods. Because the complexity of the concept makes it difficult for researchers to construct operational definitions, resistance has rarely been investigated empirically.

The explanations offered from psychodynamic, behavioural, family and other points of view often seem foreign to the actual experience of being resisted or of experiencing difficulty in a psychotherapeutic situation. Anderson and Stewart (1983) noted that resistance felt personal to the therapist (p. 12). What are these personal feelings? How are they lived in everyday situations? What is the emotional and cognitive involvement when difficulty is experienced that eventually leads to an explicit recognition in the verbalization that I am, indeed, experiencing (difficulty) resistance.

## 1.3 Process of Constructing This Investigation

As a psychological intern at a community mental health centre in New York State, I began to wonder about the concept of psychotherapeutic resistance in connection with spiralling costs of mental health care in the U.S.A. Cost of mental health care had never been an area to which I had paid attention until it was brought up by the director of the internship program in

a discussion during a weekly supervision session about third party payments in private practice.

Reflecting on the information at the time, I thought about my perception of the clinic as a revolving door, many clients returning for additional treatment after they had been terminated on two, three or more occasions. Reflecting upon that impression, I remembered how frequently the term resistance, resistive client, resisting the therapy was used in staffing sessions by different therapists. I wondered if spiralling mental health costs, repeating clientele and resistance were somehow connected.

My next step was to read the literature on psychotherapeutic resistance. To my surprise, I discovered that there were many diverse views as to what resistance was, where it was located and how it should be treated. The nature and manifestation of resistance in the schools of psychotherapy were, in the main, consistent with the theoretical context. I came across one attempt to move toward a convergence of views in this area (Wachtel, 1982). However, in his foreword, the author acknowledged that the attempt had largely failed. The lack of consensus in the field fed my desire to find a way to carry out an investigation that would aim to uncover the source (or the reason)

for the lack of convergence. My interest shifted to examining resistance from a descriptive perspective.

My hunch was that the origins of any conceptualization of a situation being demonstrative of resistance lay in the actual experiences of therapists in doing therapy. My aim was to obtain descriptions of the experience of being resisted and to reveal meaning components attributed to the experience as lived and remembered.

In doing so, I hoped to increase an understanding of the experience of resistance and to clarify its origins as a theoretical concept.

A pilot study was conducted with two participants who provided descriptions of situations where they experienced themselves as being resisted. When these descriptions were originally presented as part of the proposal for this thesis, a great deal of discussion took place about the concept of resistance, resistive clients, resistive therapists, the client's experience of being resisted by the therapist and the therapist's experience of being resisted by the client. Some committee members were concerned that if the study only considered resistance from the therapist's perspective, this would strengthen an already pervading view amongst many therapists that clients were

resistive to therapists without giving thought to the possibility of therapists being resistive to the client. Others were concerned about the passionate nature of the responses the concept of resistance elicited amongst many psychotherapists, and the resulting risk that only psychotherapists of particular theoretical persuasions
would be willing to participate in this study.

Reflecting on that beginning, it appeared that a better way to proceed could be to ask psychotherapists to describe therapy situations in which they had experienced particular difficulty. The rationale for this procedure was that psychotherapeutic resistance may have been conceptualized as an explanation for the therapist's experiencing of difficulty without really first examining it in a systematic and meaningful manner.

## 1.4 Nature of the Present Study

The present study is reformulated as an investigation of manifestations of experiences of difficulty in a psychotherapy situations from the therapists' perspectives. The term difficulty as used in this investigation is to be understood as indicative of particular difficulty in the therapy as opposed to a

fleeting or momentary impasse. Although not all therapists accept the concept of resistance, it was assumed that most, if not all therapists have experienced difficulty at one time or another. At the same time, the objective of making statements about the relationship between the experience of difficulty and the concept of resistance remain an important part of the study. It was proposed that an increased understanding of difficulty in psychotherapy will increase our understanding of how the concept of resistance emerged and the kinds of purposes that were served through the conceptual invention of psychotherapeutic resistance.

## 1.5 Purpose of the Investigation

The primary purposes of the investigation are: a) to provide a description of what it means to experience particular difficulty in psychotherapy; b) to contextualize the role of the concept of resistance in therapy in light of this investigation; c) to contribute to a growing literature concerned with meaning in psychotherapy.

## 1.6 My Interest in the Study

As a practicing psychotherapist, I am interested

in gaining a clearer understanding of some of the concepts that refer to our work. Not only does doing an interpretative study grounded in experiencing provide me with an opportunity to arrive at a clearer grasp of situations I have experienced, but it also provides the opportunity to do so in a manner that bridges the gap between research and practice. It can do this, because it is grounded in praxis (in this case the praxis of psychotherapy) and reflects on that praxis.

One of the criteria for doing interpretative studies is that one has an initial idea of how a particular experience is meaningful to participants. As a psychotherapist, I have some idea of what it is like to experience difficulty in a psychotherapeutic situation, but I have never really examined the actual experience in a descriptive manner. Subsequently, along with obtaining descriptions from other therapists, I also completed a description of the experience from one of the therapy situations I was in. This was done to obtain a sense of problems that others could have in providing the description and to be able to compare my own experiences with those of other participants. (See Appendix 1 for the description provided by the author.)

## 1.7 Importance of the Study

This use of a reflective look at experiencing as it is recalled, has largely remained outside the realm of psychotherapeutic research. By utilizing this method, an opportunity is provided for studying meaning attributed to experiences. No attempt is made to prove or disprove cause-effect relationships among the relationships identified in human action, but rather an attempt is made to gain a clearer understanding of the meaning attributed to our experiences.

Packer (1985) suggested how an interpretative account could be useful for psychologists:

> Such an approach considers action and social interchange in the rich complexity that we all, in our everyday dealings, know them to have. It does not provide the forms of explanation that we have been taught to consider characteristic of scientific rigour and some will reject it on this basis. The end product of a hermeneutic inquiry - an interpretative account - is more modest in its aims than is a formal set of rules or a causal law, but at the same time, it is, I believe, subtle and complex, intellectually satisfying, and more appropriate to human action, embracing the historical openness, the ambiguity and opacity, the deception, dangers and delights that action manifests. (p. 1092).

An understanding of difficulty in psychotherapy entails an understanding of the manifestations of difficulty and the shared world where therapy and communication about that difficulty intersect.

Before examining the actual construction of the

study, findings and interpretations, a review of the literature on psychotherapeutic resistance will be given in the following chapter.

# 2. LITERATURE REVIEW

## 2.1 Introduction

A major premise of this study is that the experience of particular difficulty in psychotherapy situations is intimately related to the concept of psychotherapeutic resistance. Given the tradition of descriptive inquiries to proceed by initially examining literature and research on the subject matter as it emerged through traditional modes of inquiry, the starting point of the present inquiry will be to review the various theoretical positions about the nature of resistance. In providing a background to this inquiry, the review will demonstrate how traditional research limited itself to explaining primarily client behaviour without prior rigorous and systematic descriptive investigations of its manifestations and attributed meanings attentive to the therapist's experience as well as the client's experience.

## 2.2 Psychotherapy Resistance - An Historical Overview

Resistance to psychotherapy or medical treatment is something that experienced clinicians and philosophers have known about for thousands of years.

Ellis (1983a) wrote: "Ancient philosophers such as Confucious, Gautama Buddha, Epictetus, Seneca and Marcus Aurelius - recognized that people voluntarily pursuing personality change often resist their own and their teacher's best efforts". (p.28)

Menninger (1958) observed that "the traditional attitude of medicine throughout the centuries had been to ignore this opposition, to treat it with equanimity" (p.104). Generally it was thought that resistance arose from fear of accepting treatment from the helper. Prominent nineteenth century practitioners (Braid, Hippolyte, Charcot...) began to place emphasis on resistance as a factor that needed to be overcome in psychotherapy. However, psychotherapeutic resistance achieved its greatest prominence in Freud's psychoanalytic theory and has since remained as a major concept in most theoretical models.

### 2.2.1 Psychoanalytic Theory

Freud described resistance as being all behaviour which interfered with the avowed aim of therapy, which, he contended, was the making conscious of what was unconscious and helping the patient to substitute sublimation in place of other defenses.

Menninger (1958) observed:

> Resistance as it is used in psychoanalytic theory may be defined as the trend of forces within the patient which oppose the process of ameliorative change. It is not the analyst who is being resisted; it is the process within the patient which the analyst is encouraging. (p.104)

Freud conceptualized resistance in light of man's inherent regressive nature. Singer (1965) wrote:

> ...resistance was to Freud a natural phenomenon because it is in line with what he proposed was the inherent nature of man. The neurotic, essentially libidinally fixated character is bound to resist what might dislodge him from his natural tendency toward fixations. The resistance of the awareness of id impulses were said to protect the patient from the consequences acting on them would bring - castration, presumably dreaded by the boy primarily because it would forever preclude the fulfillment of man's ultimate hope: regression through union with the mother or her substitute. (p. 230)

Originally Freud thought resistance was strictly a manifestation of the ego to support the individual's function in the real world against his unacceptable impulses. Part of the function of the ego was to keep the impulses repressed and "this inadequately performed function of the ego...was said to express itself in the therapeutic exchange" (p. 226). Later on, Freud elaborated on the role of the superego in the form of masochism as an important contributor to resistance. Singer observed:

> Freud (1933)...conclude[d]:

> ...that masochism brought about by the patient's severe superego is prominently responsible for the development of resistance. The patient is eager to remain neurotic, to suffer and atone for what he considers his guilt, he does not really wish to feel better because he does not believe that he has yet fully atoned. The dissolution of the neurosis would deprive him of opportunities for suffering and atonement.... Therefore the patient holds on to his neurotic symptoms, continues his self punishment, resists the resolution of the neurosis and rejects insights which would bring about a resolution and subsequent alleviation of his condition. (P. 227-228)

Resistances were perceived as acting in the service of the patient's atonement for his incestuous impulses, an atonement necessary for the prevention of castration by the punishing father.

Freud's theory of the origin of resistance among female patients conceptualizes that women had never given up their secret ambitions of being a man and therefore act in their neuroses like men. Singer observed: "Penis envy, the fear of loss of a fantasized phallus and similar constructs had to be developed in order to account for the obvious fact that women do become neurotic and show as much resistance as male patients" (p. 229).

In addition to resistances that originated in the ego and in the superego, Freud (1959) described three additional sources of resistances (p. 86). Transference resistance refers to the patient's

transferring of repressed material upon the therapist. Menninger (1958) described:

> It expresses the patient's resentment at not getting from the analyst (as a representation of an earlier figure) the expected response; it bespeaks the mounting frustration and anger of this disappointment. It is as if...he had become less eager to try to please the analyst and almost too angry to want to tell him anything... (p. 106).

Episonic gain resistance refers to the secondary gain of a patient from his difficulties. These resistances are perceived as "being recently acquired devices as opposed to lifelong habits and lie predominantly in the conscious and preconscious" (Ibid). Other theoretical orientations have adapted the notion of "secondary gain" as a source of resistance in their models (Munjack and Oziel, 1978).

Repetition compulsion resistance emanates from the id and is "usually found at a level after the ego decides to relinquish its resistances" (Menninger, 1958, P. 106). It occurs as the ego attempts to undo its repressions and is a function of the "attraction exerted by the unconscious prototypes upon the repressed instinctual process" (Ibid.). Freud described it as relating to the self-destructive principle.

In summary, in orthodox psychoanalytic thought,

resistance is omnipresent. Freud (cited by Menninger, 1955) stated:

> Every step of the treatment is accompanied by resistance; every single thought, every mental act of the patient's, must pay toll to the resistance and represents a compromise between the forces urging towards the cure and those gathered to oppose it. (p. 102)

For many psychoanalysts, the whole rationale of interpretation is devoted to overcoming patient resistances. Anderson and Stewart (1983) observed:

> ...in the psychoanalytic approach to treatment, resistance is not something to be overcome to get to the real "issues" of therapy since working through resistance is the therapy...much of the therapy consists of analyzing when, what, why and how the patient resists exposing his/her thoughts and feelings and the significance of what such resistances reveal about the patient's problems. In other words, psychoanalysts use an exploration of the patient's natural resistance to achieve understanding and change (p. 5-6).

### 2.2.2 Other Psychodynamic Views

Singer (1965) noted a similarity in conceptualizations of psychotherapeutic resistance amongst all psychodynamic therapists:

> ...that resistance is a mechanism in the service of avoidance, in the service of keeping buried what the patient hopes will remain buried because he wishes to avoid the anxiety that would ensue were this material not repressed. Thus all schools of thought view resistance as opposition to the unearthing of anxiety and terror provoking material. (p. 231)

Yet one notices different emphases as to the

origin of resistance. Jung perceived the symptomatology of incest to be a secondary phenomenon within an already pathological process. He insisted that the unconscious contained not only anxiety provoking personal experiences that were repressed but also "past collective experiences of mankind" (Ibid.). He believed that a resistance to these experiences was a function of the tremendous anxiety which sets in when "this possible upsurging of irrational material constitutes a threat to the orderly, stable existence of the individual...is a threat to the niche the person for better or worse has established for himself in the world" (Ibid.).

Although Adler agreed that resistance was directed against noxious insights, he did not accept Freud's view of resistance as reflecting instinctive regressive processes. He perceived that resistance arose "whenever the patient senses that his feelings of superiority are threatened and that feelings of inferiority were likely to follow" (Ibid, p. 230).

There are a number of psychodynamic approaches that view resistance as a patient's "heroic efforts to survive and the particular methods he considers essential to fight successfully" (Ibid., p. 233). The neurotic aspect of resistance is the inability of the

patient to see that premises which were valid for survival yesterday are not necessarily valid in their present situations. Sullivan (1953) remarked that the resistance "reflects a pretty remarkable manifestation of human dexterity in living" (p. 11). One observes a recognition of the adaptive value of resistance in this conceptualization.

Psychodynamic theorists with existential biases link resistance to feelings of despair and the patient's disbelief in alternative solutions. Singer stated:

> The patient's resistance...is a struggle against the awareness that his life has no predetermined meaning and therefore demands his personal self definition...In reflecting insight and in avoiding self understanding - in resisting - the patient expresses his preference for the despair inherent in the recognition "I have no choices" (p. 246).

The therapist serves as a model of hope for finding better methods to maintain oneself. The therapist attempts to help patients abandon the despair of all choices so that they will ultimately acknowledge that choices have been made and in so doing are affirmed.

### 2.2.3 Robert Langs' Communicative Theory of Therapeutic Process

Although accepting of classical psychoanalytic

definition of neuroses and their treatments, Langs (1980A; 1980B) deviated from the psychoanalytic view in his communicative approach to resistance and interpretation. Langs was critical of psychoanalytic theory for its near exclusive focus on intrapsychic forces, transference and manifest behaviours in its explanation of resistance. He stressed the role of therapeutic interaction or bipersonal field and its contribution to resistance. Briefly, he recognized the never-ending interplay between interactional factors and intrapsychic needs. He believed that the nature of the interpersonal exchanges between therapist and patient determined the extent to which the patient cooperated at the unconscious level in providing interpretable material. He suggested that it would seem best "to think of all resistances as interactional resistances and then to sort out contributions from the patient and the therapist" (p.508).

In the communicative approach, communicative resistances are examined as to whether they could be traced back to adaptive context in the bipersonal field. By adaptive context, Langs referred to the external reality stimulus for an intrapsychic response. He noted that many resistances classically viewed as arising from transference may actually be

adaptive in nature and a function of external reality stimuli that serve as neurotic adaptive context. Indeed, Robert Langs was very critical of the concept of transference and perceived it as being too widely applied to patients at the expense of therapists analyzing their own contributions in the process. He wrote:

> Expressions of counterresistances in the analyst are treated as if they were transference resistances and problems within the therapist are handled as if they existed within the patient. A more accurate approach would acknowledge, rectify and interpret the analyst's contributions to the patient's resistance and allow subsequent material to reveal other distortions. (p. 490)

Langs moved one step further and suggested that in most instances when therapists corrected their contributions to resistance, "a remarkably high number of (patient) resistances disappear in this way entirely without active intervention" (p. 567).

Langs considered the assessment of resistance in classical approaches to be subjectively derived. He contended:

> It is usually based on the therapist's feelings and his inner state, as well as evaluations of the patient's material. Such an assessment is under the influence of inputs from both the patient and the therapists and while it constitutes a decision of the latter, it is nonetheless a product of the bipersonal field (p. 508).

Elsewhere Langs (1980b) noted:

> The very formulation by the analyst that a patient

> is in a state of resistance is both a subjective assessment open to error and under the influence of inputs from both patient and himself. The evaluation, then, while located within the analyst, is nonetheless a product of the bipersonal field. This consideration was adumbrated by Szasz's (1963) unique comment regarding the role of subjective evaluation in the analyst's assessment of the presence of transference manifestations and distortions. Szasz recognized that this particular appraisal could be valid or invalid, the latter serving the defensive needs of the analyst. Klauber (1968) in his investigation of the influence of the analyst's personality on his assessment of the patient's resistance makes this point quite specifically: all such evaluations are open to personal bias and the influence of the analyst's values and character structure. These comments have been largely ignored by other writers (p. 28).

Langs (1980a) pointed to "the subjective feelings of therapists and the sense in some way the client is opposing therapeutic efforts" (p.508) as a major factor for identifying resistances. The manner in which he or she listens to and organizes the client's behaviour and associations and the type of validation the therapist applies to his or her interventions determines to a large degree whether or not resistance is identified.

It seems that Langs' most important contributions were the recognition of the importance of examining interactions between therapist and client in determining whether specific client statements reflected resistance and a shift in perspectives that recognized countertransference and other therapist

behaviours and attitudes as important contributors to client resistance. In this context communicative theory accepted many client behaviours as being examples of adaptive functioning as opposed to being examples of transference resistance.

### 2.2.4 Behaviour Therapy

Traditionally, the concept of resistance has occupied a minor place in behavioural therapy. Goldfried (1982a) observed:

> The concept of resistance rarely if ever arose in the early literature on behaviour therapy. Most of the original descriptions of behaviour therapy conveyed an underlying assumption that, apart from their presenting problems, clients were totally "rational" beings who readily complied with the intervention procedures set forth (p. 95).

Jahn and Lichstein (1980) noted how the nature of the assumptions underlying behaviour therapy contributed to that school's resistance of resistance as a major concept.

> ...Is it not curious that resistance makes the behaviour therapist directly confront his learning theory assumptions concerning the acquisition and maintenance of behaviour. The resistive client directly defies the contingencies set by the therapist and the regulation of behaviour via contingency management is a basic tenet of behaviour therapy.... (p. 313)

Increasingly it became clear to behavioural therapists confronted with difficult problems that a

simple application of the appropriate technique was not always successful in spite of the therapist's best efforts. Goldfried (1982a) elaborated:

> Although the therapist might have been clear about the determinants associated with any problem behaviours, and may also have felt confident that certain therapeutic techniques had a good chance of bringing about the needed change, the clarity of the clinician's thinking was not always matched by the client's desire or ability to comply with the intervention procedures. It has been in the face of such instances of therapeutic noncompliance that the topic of resistance has come to the fore in behaviour therapy. (p. 95)

A number of elements that Goldfried identified as possible contributors to client resistance included resistance as a symptom of the client's presenting problem (i.e. procrastinating clients who never seem to get around to doing their homework assignments), resistance resulting from client's other problems, a pessimistic attitude toward the chances of change, fear of change and minimal motivation to change (Ibid p. 105-109).

Jahn and Lichstein (1980) observed that resistance is identified when clients are "countercontrolling when they act in opposition to the contingencies set by the therapist, resist the therapist's attempts to change them, or are not motivated to work on alleviating their presenting problems" (p. 305). Munjack and Oziel (1978) identified five types of resistances in their

behavioural treatment of sexual dysfunctions. Type I was resistance as a function of the client not knowing what he or she was supposed to do. Type II resistance was related to deficit in skills for carrying out the treatment requirement. Type III resistance was identified as resulting from a lack of motivation or an expectation of failure. Type IV resistance was described as being a result of anxiety or guilt. Type V was defined as being a result of secondary gain from the problematic behaviour.

Two features stand out in examining the concept of resistance in behavioural therapy. First its recognition as a factor coincided with the increasing acceptance amongst behaviour therapists that internal features such as client motivation and emotional features such as guilt, shame and anxiety can play a role in the therapeutic process. Secondly, resistance was not conceived as being inevitable. Goldfried (1982a) suggested that there was "nothing intrinsic to the behavioural model of change - at least in principle - to suggest that difficulties in implementing the therapeutic procedure are to be anticipated" (p. 98).

### 2.2.5 Cognitive-Behavioural Therapy

Like the traditional behaviour therapies,

cognitive-behavioural (c-b) therapists have traditionally placed limited emphasis on psychotherapeutic resistance.

Frequently it was viewed as a "rationalization that therapists employ to explain their treatment failures" (Fay and Lazarus, 1982a, p. 115). Indeed they saw the concept as being vastly overemphasized among psychodynamic theorists at the expense of looking at their own contributions to the process. Fay and Lazarus commented:

> By insisting on an unconscious focus for resistance, some therapists compound the difficulty of understanding and resolving intricate clinical problems. A patient may intentionally withhold information and otherwise refuse to participate in treatment because of fear, shame or distrust of the therapist. Unfortunately, those who maintain that unconscious resistance invariably lies behind these deliberate factors deflect responsibility back onto the patient's intrapsychic forces instead of examining situational events (e.g. the therapist's failure to create a climate of trustworthiness for a particular confidence to be shared. (Ibid., p. 117)

Recently, however, there has been an increasing amount of literature about this concept as cognitive-behaviour therapists have grudgingly come to recognize treatment failures even in this form of therapy (Ellis, 1983a, 1983b; Golden, 1984; Meichenbaum and Gilmore, 1982; Fay and Lazarus, 1982b). Generally the

literature from a c-b viewpoint has been focused on ways for conceptualizing and treating this pervasive problem. Meichenbaum and Gilmore (1982) described resistance as client difficulty in finding and testing "possible alternative coping strategies, both behaviourally and cognitively" (p. 152). Golden (1984) uses an even broader definition by referring to resistance as "the failure of the client to comply with therapeutic procedures" (p. 33). Cognitive-behavioural therapy recognizes that client reistance to treatment may stem from any number of sources, and allows for a broad spectrum of direct and indirect interventions for overcoming this phenomenon. These include techniques developed in other frameworks such as positive reframing and paradoxical techniques as well as traditional behavioural techniques (shaping, relaxation training, contingency management). As Fay and Lazarus (1982b) observed:

> We have found that flexibility in therapist's personal style as well as a full technical armamentarium will facilitate the disruption of resistant patterns and permit a smoother course of therapy.... The possibilities for overcoming resistance and achieving favourable results in a short time are often limited only by the therapist's imagination and capacity to shift into different behavioural and affective modes.... What ultimately matters is what we say and do in the therapist's setting. (p. 230)

Their focus on cognitive structures and internal

dialogues have enabled them to observe how one's theory and one's internal dialogue can be resistive to change in a similar manner as clients are resistive to new ideas. Meichenbaum and Gilmore (1982) explained:

> Exactly how do we as scientists change? What is the nature of the forms of resistance that we as scientists exhibit? What scientists can question or modify, or what they can invent or change, and be severely constrained by their "paradigm" (Kuhn, 1967) and by the structures of their tacit knowledge (Polany, 1959) which permit their understandings and beliefs. Cognitive structures guide and influence the types of experiments (behavioural acts) that a scientist conducts, which in their turn yield results (consequences). But as scientists we are quite selective (as indeed we should be) about admitting whether or not these results are to be considered "anomalous". Our paradigms and our behaviour are quite resistant to change as is the behaviour of our clients. (p. 135)

Ellis (1983a, 1983b) from his Rational Emotive Therapy (RET) approach detailed how seemingly resistive client behaviours are often healthy responses to therapists' mistaken assumptions regarding client problems. Ellis (1983a) contended:

> From a rational emotive view, clients who resist for healthy reasons are explicitly or implicitly telling themselves rational beliefs (rbs) such as: "My therapist is probably wrong about my having this symptom or about the origins of my having it; too bad; I'd better ignore his or her interpretations and perhaps get another therapist" (p. 29).

In his 1983b article devoted totally to how therapists are their own worst enemies, Ellis lists

five irrational beliefs that reduce the effectiveness of the therapist and enhance client resistance. They are:

> (a) I have to be successful with all of my clients practically all the time.
> (b) I must be an outstanding therapist clearly better than other therapists I know or hear about.
> (c) I have to be greatly respected and loved by all my clients.
> (d) Since I am doing my best and working so-hard as a therapist, my clients should be equally hard- working and responsible, should listen to me carefully, and should always push themselves to change.
> (e) Because I am a person in my own right, I must be able to enjoy myself during therapy sessions and to use those sessions to solve my personal problems as much as to help clients with their difficulties. (p. 4-5)

Ellis continued and provided an outline of RET techniques for recognizing and disputing one's irrational beliefs and replacing them with rational beliefs that Ellis claimed would help the therapist become more satisfied and happier. Perhaps as important, Ellis demonstrated in the context of the RET approach how therapists are similar to their clients in that they, too, often develop irrational belief systems and that they, too, often have difficulties in giving up ineffective ways of viewing a problem for different ways that could be effective.

Cognitive-behavioural therapists seem to have few

pre-conceived limitations about the origin and treatment of resistance. As an action-oriented approach, c-b therapists have not only developed measures for overcoming resistance, but they have also inquired into ways of preventing resistance from occurring and from disrupting one's therapeutic work. Golden (1984) listed a number of preventative techniques including:

(a) Educating client to treatment and its rationale.
(b) Tailoring the treatment so that it fits client's daily routine.
(c) Use "shaping" or successive approximations with client's receiving complex treatments.
(d) Make use of self-monitoring techniques.
(e) Make use of social support from family and friends when possible.
(f) Have client design their own assignments whenever possible.
(g) Prepare clients for difficulties... (p. 36-37).

2.2.6 Gestalt Therapy

Resistance in gestalt therapy is viewed as an isolated part of an individual that needs to be reunited with his/her wholeness (Levitsky, 1976; Polster, 1974; Enright, 1970; Perls, 1975...). Stemming from a holistic view, gestalt therapy views attempts to remove resistance as being futile because the person who has resisted is constantly in a process of emerging as a new person and there is no way to

return to what he or she was in the past. Instead of being perceived as a saboteur and belonging to the anti-self, resistance is perceived by gestalt therapy as part of the personality and "a creative force for managing a difficult world" (Polster, 1974, p. 51).

Fritz Perls (1975) discussed the origin of resistance and its role in the client's life in the following manner:

> Resistance is great because the patient has been conditioned to manipulate his environment for support. He does this by acting helpless and stupid; he wheedles, bribes and flatters. He is not infantile but plays an infantile and dependent role expecting to control the situation by submissive behaviour. He also plays the role of an infantile adult. It is difficult for him to realize the difference between mature behaviour and playing an adult. With maturation the patient is increasingly able to mobilize spontaneously his own resources in order to deal with the environment. (p. 76)

Five different kinds of resistant interaction are recognized in gestalt therapy. They are:

(a) Introjection - patient passively incorporates what the environment offers.

(b) Projection - patient disowns parts of self and ascribes them to the environment.

(c) Retraflection - patient abandons any attempt to influence his environment. He becomes a self-sufficient unit.

(d) Deflection - patient engages the environment

on a hit or miss basis.

(e) Confluence - patient yields to the trends and lets it carry him along.

Gestalt therapy treats resistant interaction not as something to be overcome, but as personality aspects to be identified and made one's own. Levitsky (1976) elaborated:

> The gestalt approach to resistance involves the same principles as the gestalt approaches to all problems, namely to locate and contact sources of energy and by freeing and expressing them to make them available for creative use rather than have them bound up, dissociated, and pulling against the self... (p. 121).

The treatment approach is direct in that clients are encouraged into more intense and full expression of their resistive interaction style. Contact with one's environment improves through a magnification of the experience of one's resistive style leading to a reintegration of this aspect of personhood into one's totality. Resistance in this framework is conceived as an integral part of one's personality.

### 2.2.7 The Systemic Therapies

The systemic therapies represented a fundamental shift away from viewing human problems as a function of intrapsychic and linear mechanisms towards a framework that focuses on relationsips between people and how

within reciprocal relationships problems emerge. (Bogdan, 1986; Lockhurst, 1985; Saba and Fink, 1985; de Shazar, 1984a, 1984b, 1985; Lerner and Lerner, 1983; Keeney, 1983; Will, 1983; Solomon, 1974; Watzlawick, Weakland and Fisch, 1974; Shapiro, 1972). In this orientation resistance was initially viewed as something that resided in the family. The notion of the homeostatic force was utilized to explain the origins of resistance in families. Homeostatic forces were viewed as those energies which kept family behaviour within an acceptable range and which enabled families to maintain a sense of stability in their relationships. This was observed to be as true in families with member(s) identified as dysfunctional in their midsts as for families where all members were described as being nonproblematic. Solomon (1979) observed that "the family either consciously or unconsciously is working in a sort of coalition to maintain itself as it is..." (p. 15). There is a wide range of behaviour within which many families feel comfortable and thus can tolerate unusual amounts of problems among family member(s) before defining the behaviour as a problem.

Families are resistive because of their desire to assert their own will. Anderson and Stewart (1980)

observed that as autonomous entities members may have problems developing dependent relationships outside the family. They related this partially to a cultural expectation that one should be able to make it on their own. They noted that "therapy is often viewed as humiliating because it implies that individuals or families can't solve their own problems" (p. 31). This is a common feeling, particularly among individuals and family members who are very successful in other aspects of their lives.

One of the predominant viewpoints in family therapy literature has been what Bogdan (19865) referred to as a "functionalist viewpoint" which points to an assumption that symptoms serve a function in the family. It is believed that problematic behaviour by one or more family members masks more disturbing problems at a different level. At conscious or unconscious levels, family members may perceive the risk involved in symptom alleviation to family stability may in fact be far greater than one or more members continuing their symptomatic behaviour. For example, an acting-out adolescent may be viewed as protecting her or his parents from overt marriage problems. From a functionalist perspective, resistance to change would be viewed as serving an adaptive

function in its attempt to maintain current family structure. Therapists would be resisted because as agents of change they would be viewed as a threat to family cohesion and stability.

The pervasiveness of resistance to therapist efforts has led many therapist-theorists to formulate that it was families' inabilities to accommodate to change that brought them to therapy, not their desire for change (Anderson and Stewart, 1983; Keeney, 1983; Lockhurst, 1985). Events such as changes in one individual's behaviour or family life cycle events such as the birth of a first child, grandfather moving in, all the children reaching school age, career change by one spouse and children beginning to leave the nest are all events that family members need to accommodate to. As sources of stress and tension, family members strive to keep things the way they were as much as possible in face of change. Anderson and Stewart (1983) observed: "There are many factors which contribute to the resistance exhibited by a family. However, the major sources seem to be a family's natural striving for stability and a family's equally natural, if sometimes irrational fear of change..." (p. 38).

Lockhurst (1985) urged that the changes families seek be recognized as a desire for change toward

stability as it struggles to maintain its organization. Resistance that emerges should be viewed as the system's request for stability.

A departure from traditional systems thinking as to the origins of psychotherapeutic resistance was reflected in cybernetic and constructionistic conceptualizations (Lockhurst, 1985; de Shazar, 1984, 1985; Keeney, 1983).

In referring to the distinction between operational descriptions which refer to the regularities of a system as an autonomous whole and symbolic descriptions which refer to the regularities between two interdependent systems, Lockhurst (1985) observed that historically resistance was described as an operational description of an autonomous system. She contested:

> Understanding resistance in the domain of the system's interdependence with other systems allows us to hold fast to resistance as a description of, or metaphor for, the relationship between the therapist and the family. Resistance is a description of what the observer is observing (p. 9).

The cybernetic perspective has served to unreify the concept of resistance and include the observer as a participant in its construction. Recognized in the shift was the active participation of the therapist in determining whether or not a behaviour or set of

behaviours could be explained by resistance and how. Recently, de Shazar (1984a, 1984b, 1985) chose to discard the concept and replace it with the concept of cooperating. He described behaviours usually associated with resistance as families unique ways of cooperating. He believed the role of a therapist was to determine how a family cooperates and to promote change by joining the family's manner of cooperation. In this approach homeostasis as an organizing concept was replaced by morphogenesis. Morphogenesis referred to how families allow therapists to join with them in the therapeutic process in much the same manner that partners help each other in "doubles tennis". de Shazar's (1984b) considerations are strictly pragmatic in terms of utilizing conceptualizations that for him most effectively fit a rapid achievement of the therapeutic goal. He wrote:

> Regardless of the usefulness (for some) of the concept of resistance, the concept may or may not be part of any particular therapist's map-making tools. Either a map of London's bus system or a map of the underground system will frequently allow the traveller to get to the same place by different routes, even though the details of each map are strikingly different. Saying that (the reified concept of) resistance exists is like saying to the tube rider that "a good map must include all the cross-streets" and therefore the subway map is invalid even though it gets you where you want to go (p. 21).

Bogdan (1986) in his discussion on whether

families needed problems or not utilized what he called an "accidentalism" point of view which provides a further demonstration of how resistance may be conceptualized from a constructivistic point of view. He explained:

> Given this framework, how does an accidentalist explain the phenomenon of resistance. Let's say that along the way I developed the idea that you are a meddlesome person. Then your effort to help me may be interpreted not as an instance of "help," but as an instance of "meddling". My ungrateful response to you may seem bizarre and this may persuade you that I need even more help than you had supposed. But your increased efforts to help are only likely to persuade me that you are even more of a busybody than I thought. That is, your view of me may lead you to behave in ways that repeatedly confirm my view of you and vice versa. In this literally haphazard way, all kinds of problems arise and are maintained. The chief claim of the accidentalist is that that is all there is to it (p. 35).

In Bogdan's example, one sees how therapists' understandings of clients' actions may be inaccurate and lead to therapist definitions of what is happening for the client quite distant from the client's actual experience. The accidentalism viewpoint is phenomenological in that one's definitions and beliefs are derived from one's world-situated experiences and involves an attempt to understand the meaning of another's experience in a situation.

Many of the innovative views of resistance and cooperation such as de Shazar's ideas were adapted from

the work of Milton H. Erickson. He utilized all behaviours clients brought to the therapy session in his therapy and hypnotic techniques. Erickson (cited by Lankton and Lankton, 1983) once wrote:

> If they bring in resistance, be grateful for that resistance. Heap it up in whatever fashion they want you to - really pile it up. But never get disgusted with the resistance.... Whatever the patient presents to you in the office, you really ought to use it (p. 10).

The systemic therapies served to shift resistance from a lineal conceptualization as an explanation for a process that occurs to or within an individual to a circular conceptualization as an explanation for a process that occurs in an interactional context. Initially, resistance was characterized as something located in family boundaries. Later writings characterized resistance as referring to the interdependent relationship between therapist and client which served to recognize the therapist's role in defining what experiences would be labelled as resistance and in what manner. Subsequently a number of therapists have questioned the value of resistance as an explanatory and practical concept in psychotherapy which has led to its demise in some orientations.

## 2.3 Resistance and the Schools of Psychotherapy - A Comparative View

Resistance has been utilized by different schools of psychotherapy as a way of explaining difficulties of one form or another that therapists face in their attempts to get clients and families to change. At the same time, the schools use the concept in vastly diverse ways ranging from resistance as being viewed as a clinical phenomenon to being viewed as a mechanism for talking about a clinical phenomenon to being viewed as an outdated and expendable concept. In this section, the schools will be contrasted along five dimensions. These include: (a) adaptive vs. nonadaptive functions; (b) contribution of the therapist; (c) inevitability of resistance; (d) resistance as a reflection of society's core value of independence and autonomy; (e) a political question.

### 2.3.1 Adaptive vs. Nonadaptive Functions

Most schools of psychotherapy seem to view resistance as having adaptive and nonadaptive functions. In classical psychoanalytic theory, resistance was viewed as operating in the service of the neurotic compromise between basic regressive tendencies of the pleasure principle and the demands of

the reality principle. Resistance, which is intrapsychic in nature, was perceived as impeding the analyst's work of bringing to conscious awareness through the process of interpretation the whys of the person's conflictful behaviour. In this sense, resistance was viewed as being nonadaptive and a hindrance to psychological improvement. At another level; that is, viewed from a pure intrapsychic level, resistances were perceived as being adaptive in that resistances served as a protection against the threat of a greater nature, the giving of expression to forbidden libidinal impulses. Dewald (1982) wrote:

> From the patient's point of view...the same behaviours that are labelled "resistance" by the therapist serve an immediately useful and adaptive purpose. From the vantage point of the patient's unconscious neurotic recesses and psychological organization, they represent his attempts at maintenance of the status quo. They protect the patient against conscious awareness of unacknowledged and unpleasurable elements within his own psychic life; and they promote and sustain the continuing search for fulfillment of inappropriate drives, fantasies and relationships. (p. 48)

Similarly, early systemic conceptualizations of resistance in families also ascribed a protective function to the concept. Unlike psychoanalytic theory which ascribed the protective function at an intrapsychic level, systemic conceptualization placed the protective function at an interpersonal level.

In addition to a protective function, some systemic theorists attributed other features as well. Anderson and Stewart (1983) listed:

> Without a certain amount of resistance to change, all social systems would dissolve into chaos and confusion, responding helter-skelter to every input received. Without a certain amount of resistance to change, a family would be unable to provide the stability necessary for its members to grow and develop. Without a certain amount of resistance to being influenced, families and individuals would be converted by every medicine man, commercial or talk show "expert" that happened to bend their collective ear.... (p. 4)

Behavioural and cognitive-behavioural therapists tended to view psychotherapeutic resistance as being non-adaptive for client and therapist alike in the sense that it interferes with the therapeutic task. The onus was placed on the therapist to uncover the origin of a client's resistances and to provide interventions to eliminate them so that task-oriented therapy could progress. Resistive behaviour was perceived as being adaptive in situations where clients did not comply with inappropriate therapist suggestions and interventions.

### 2.3.2 Contribution of the Therapist

Save for classical analytical theory and gestalt therapy, the different paradigms generally perceived

the therapist as being a generous contributor to psychotherapeutic resistance. Langs (1980) described how countertransference, inappropriate interpretations and other elements played a large part in preventing patients from presenting interpretable unconscious data. Amongst Lazarus and Fay's (1982a) seven factors of resistance, five factors alluded to therapist failure. Examined earlier were Ellis (1983b) delineation of therapists' irrational beliefs. Because of the gestalt therapy understanding of resistance as a client's interactional style, therapist contribution was not generally examined. However, literature on gestalt therapy was very clear about the limitations of applying interpretative and working-through strategies when faced with difficulties in therapy. Traditional treatment strategies were seen as contributing to the client's resistive style of interaction.

In contemporary systemic thinking it was noted how a therapist's inattentiveness to family's request for change also included a request for stability could lead to resistance and alienation. In addition, therapists were perceived as contributing to resistance when problems are attacked independent of the interactional context from which they emerged. By being blind to the power of context, by being unaware how individuals mutually affect each other's behaviours, by offering

more of the same solutions, by not seeing oneself as part of the context that is being influenced as well as influencing, by maintaining a rigid one-up position (as the expert) in all situations, the therapist can contribute heavily to individual/family resistance. Haley (1986) delineated a number of ways therapists could fail. He presented fourteen tactics that a therapist could utilize to enhance the possibility of failure. These included: (a) insist that the problem which brings the patient into therapy is not important; (b) refuse to treat the presenting problem directly; (c) put emphasis on a single method of treatment; (d) insist that only years of therapy will bring the desired change....

### 2.3.3 Inevitability of Resistance

For psychodynamic practitioners, resistance is inevitable in the therapy process. As noted, Freud observed that resistance accompanied each step of the analytic work and theorists following him have accepted this viewpoint. Schlesinger (1982) wrote: "It is one of my articles of faith, or at least a heuristic assumption that in psychotherapy defense and transference and hence resistance are always present" (p. 31).

Using an analogy, Schlesinger demonstrated how its

manifestations may be in the form of very subtle behaviours:

> To draw an analogy from the late, late show if the resistance wants to prevent a train from reaching its destination, it is not necessary to blow up a bridge. It may be enough to throw a switch the wrong way, to bribe the conductor, to mislabel some cars or to uncouple them. The most economical way for the underground to function is to achieve maximum disruption of the enemy with minimum exposure. (Ibid.)

Behavioural and cognitive-behavioural therapists did not view resistance as being inevitable in the psychotherapeutic process. A client's seemingly resistive behaviour such as withholding information, not carrying out assignments or tardiness in attending sessions may be a function of situational events including therapists' errors or failures. As Fay and Lazarus (1982a) observed, the deflecting of responsibility back to the patient's intrapsychic forces could prevent the therapist from examining other possible sources for the seemingly anti-therapeutic behaviour (p. 117). They also noted an additional danger in the notion of the inevitability of resistance:

> ...it leads clinicians to be suspicious of rapid improvement in patients who have not manifested "resistance." As a consequence, ad hoc concepts such as "flight into health" and "transference cure" emerge that may lead a therapist to withhold positive reinforcement for rapid clinical change... (Ibid.).

In its notion that families operate within repetitive sequences of interaction and in its notion that some families have difficulties in changing their interactional sequences to accommodate change in circumstances, many system theorists viewed the notion of resistance as being central in the therapy context. Many of the treatment strategies developed in the strategic approaches seem to be based on a conceptualization that families seek therapy because they have had difficulties coping with changes occurring as part of the family life cycle. Resistive behaviour is perceived as being a natural process in families seeking therapy and those processes are often utilized by systemic therapists in creative ways.

Other system theorists have noted how resistance, epistemologically speaking, is a symbolic description that alluded to the interface between the therapist and family system as opposed to a description of the family as an autonomous system. Viewed as a description from an observer's point of observation, using resistance as a concept for describing or explaining a process depends upon the particular stand a therapist adopts about the behaviour. Meyerstein and Dell (1985) contended:

> There can only be resistance when the therapist thinks that the client somehow ought to be

> behaving differently than he or she is currently behaving. Our willingness to accept the client's position profoundly alters the therapeutic landscape. Instead of a field of sick patients, we find clients with interesting problems (p. 271).

Elsewhere it was noted that de Shazar had constructed a model of therapy in which resistance as a concept for explaining client behaviours was eliminated and replaced with the concept of cooperating. Stewart and Anderson (1984) rejected de Shazar's position quoting Lyman Wynne that "resistance is a thorn that by any other name pricks as deep". (p. 19)

### 2.3.4 Resistance and Society's Core Value of Independence and Autonomy

One of the major values of North American society is personal freedom and independence. Based on charters and laws that place the highest value on personal freedom, the seeds of resistance may be sown by the implicit humiliation or stigma an individual or family might experience in the very act of reaching out for help.

Anderson and Stewart (1983) observed: "The implication is that if you have the right to live your own life as you see fit, you also have the responsibility to know how to do it successfully" (p.

30).

In being part of a society that guarantees individual rights, people have generally accepted the concept of being fully responsible for living their lives in a manner they choose. Increasingly, the self-dependent dimension of human existence has been stressed in western society. Individuals prefer to view themselves as masters of their own fate. The implications for psychotherapy are profound as noted by Anderson and Stewart:

> In our society to allow oneself to be influenced is to give away one's fundamental right to self-determination, one's constitutional right to make decisions. Entering any form of psychotherapy constitutes the formation of a dependent relationship and therefore a loss of personal freedom (p. 29-30).

Ellis (1985) suggested that irrational beliefs such as "I have to control my entire destiny and even though my therapist is on my side and is working hard to help me, I must not let him or her tell me what to do" could often be found in clients who rebelled against therapy because they saw it as an impingement of their freedom (p. 16).

Brehm's reactance theory (cited by Jahn and Lichstein, 1980) provides a framework for understanding how individuals may react to perceived losses of freedom. Often they will attempt to reassert their

will by directly resisting the endeavour of those who are perceived as trying to influence them. The intensity of the resistance will depend upon a number of variables including: (a) the types of threats to the person's freedom; (b) the strength of the threat; (c) the importance of the threatened freedom; (d) proportion of individual's freedom being threatened.

### 2.3.5 Resistance and the Larger Political Question

The questioning of the heuristic value of resistance is as much a political question as it is an epistemological problem. For the longest time psychoanalytic therapists and others have justified psychotherapy of individuals, often spanning years or decades, by citing resistances as an impeding dimension to their work. Patient dissatisfaction with treatment was interpreted as being a natural part of the process. Expressions of dissatisfaction were viewed as being beneficial in the context for it provided the patient with an opportunity to work through difficulties in the transference relationship and clients were often led to believe that treatment would take a very long time.

Currently resistance is a reified concept amongst the psychodynamic approaches. It fits in comfortably

with the concepts of transference, defences and intrapsychic movements. Given its relative power and the strength of commitment and convictions amongst its members, resistance would seem to have a secure role in that context.

Amongst other theories, the relative importance of resistance in the total frameworks vary. Practitioners from all frameworks recognize a reality of very difficult clients and families with whom they often experience impasses. Resistance, borrowed from the psychodynamic approaches and modified to fit the language of the particular theory, may have served as an attempt to explain uncomfortable and frustrating situations in a relatively non-reflective manner. Yet as demonstrated in the overview, the appreciation of the concept as applied to other schools of psychotherapy was frequently made without the network and conviction of meaning found in the psychodynamic approaches.

For behaviour and cognitive-behavioural therapists, resistance has been adopted grudgingly. Generally they prefer to examine a broad range of circumstances that may be contributing to client non-compliant behaviour. Resistance is not judged as being inevitable. Indeed, behaviourists and c-b clinicians

shift the emphasis from client natural tendencies to therapist contributions. Systemic theories seem split between those who firmly accept the heuristic value of resistance as a way of conceptualizing family/individual stuckness in therapy and those who renounce any pragmatic value to the concept.

Historically it made good sense for the different paradigms to adopt resistance into their theories. Regardless of where the emphasis lay - whether it be in intrapsychic processes, therapist behaviours, family system or other interpersonal context - implicitly there is an implication that the therapist knows what he or she is doing and knows what is best for the client. Even in frameworks where inappropriate behaviours of the therapist are perceived as a major contributor, there is an underlying expectation that by correcting his or her failings, clients will become compliant to the therapy proceedings.

Throughout the years, a conceptualization of the psychotherapeutic process as reflecting a complementary relationship between therapist and client has emerged. Therapists have come to perceive themselves in the expert one-up position vis a vis their clients. From this author's viewpoint, the concept of resistance fitted well to an emergence of a view of the

psychotherapist as expert. As a safety valve for when all else failed, psychotherapists could blame their lack of success on client resistance.

In building and accepting theoretical constructions that generally explained resistance in a manner subordinated to the major theoretical precepts of the different schools, therapists have largely placed in a secondary position their own experiences in working in situations with clients or families who are perceived as uncooperative, seemingly incapable of change, or downright hostile. Experiencing of particular difficulty has been taken for granted and left unexamined.

Smith (1978) claimed that traditionally an hypothesis, with the investigators' biases and theories built into it, has served "to fill the gap of ignorance when not enough is known about what some phenomenon is" (p. 40). Occupying a stronger position Van den Berg (cited in Smith, 1978) claimed that an hypothesis only arises when the descriptive process is cut short (Ibid.). Indeed there has been no rigorous and systematic attempt to obtain descriptions of manifestations of difficult experiences in psychotherapy situations-as-lived in its different forms and adumbrations. The oversight is not however

limited to this particular experience for generally descriptive methods have been minimized in psychotherapeutic research in favor of experimentation.

## 2.4 Research On Psychotherapeutic Resistance

Research on psychotherapeutic resistance has been mainly of a theoretical or anecdotal nature. There are only a limited number of experimental studies. Golden (1983) speculated that the limited number of hard core studies was due to a general perception that the "phenomenon was too elusive and too difficult to study experimentally" (p. 41). Indeed, the kinds of behaviours defined as being resistive depends on the therapist which suggests an infinite range of possibilities. Jahn and Lichstein (1980) observed that researchers may have avoided studying resistance for "strictly technical reasons" that is, only "narrow operational definitions had been available" (p. 315).

One exception was the Chamberlain, Patterson, Reid, Kavanaugh and Forgath (1984) study. They constructed a molecular system to quantify client resistance and to examine utility of this system for reliably measuring client resistance on an event-by-event basis. Participants were twenty-seven families with problems in managing their children. Treatment

was categorized into three stages: the beginning stage when therapists explored with the parents the nature of the difficulties they were experiencing, the middle stage, which consisted of therapists teaching parents how to directly intervene in their child's problem behaviour, and the third stage when parents were helped to integrate what they learnt with their own style of parenting. It was expected that different levels of client resistance would be observed at different treatment stages. Resistance was defined as client responses such as inattentiveness or continuous confrontations. Altogether there were five response categories. Also of interest to the investigation was whether the level of resistance amongst outside agency referrals was greater than with self-referrals and whether those who completed the program had fewer resistance responses than those who dropped out. Results showed that the greatest amount of resistance was in the middle phase. Families that were agency-referred tended to have higher levels of resistance than self-referrals and significantly more higher resistant families dropped out of therapy than lower resistant families. Therapists who rated cases as being more successful were generally with those families whose levels of resistance were judged as

lower than others.

Studies about resistance have mainly been anecdotal or theoretical in nature. Sperry (1975) utilized Kohlberg's levels of moral development to devise a theoretical model for showing how resistance could be overcome and for establishing a basis for cooperation and for aiding in constructing effective clinical strategies. Saltmarch (1976) used Maslow's motivational hierarchy for characterizing levels of resistance, effects, presented experience, client intent and therapeutic task for resolving resistance at each level. Breit, Wan-Gim, Im and Wilner (1983) described strategic approaches for treating resistant families. Techniques described included symptom prescription, illusion of alternatives, role play and strategic alliances. Also from a strategic approach, Cade (1980) described how contrived team conflict could help break the deadlock with highly resistive families.

Oremland (1976) presented a case study describing how a patient's everyday situation contributed to her resistance to weight loss and described ways for working through the difficulties utilizing psychodynamic methods. Ramirez (1983) described how the House-Tree-Person projective drawing could be used in group situations to draw out resistances. Kellerman

(1983), Lienenberg (1983), and Collison (1985) described psychoanalytic methods for working through patients' resistances in group psychotherapy. Wills (1978) in an examination of literature on helpers' perceptions of clients concluded that evidence from several sources show that the attitude of most helpers toward client resistance is negative.

Missing in the literature are phenomenological accounts of situations for which resistance serves as an explanatory device. Questions regarding actual events that occur in situations defined as resistance, meanings practitioners attribute to the experience, and the difference between how this experience is lived compared to situations where resistance isn't attributed, all need to be examined. An exploration of how particular difficulty is experienced in therapy projects could provide a framework for deepening our understanding of how resistance as a concept emerged and occupied a central place in psychotherapeutic literature.

## 2.5 Phenomenology and Research in Psychotherapy

### 2.5.1 Traditional Research

In its goal to achieve academic respectability and

lay acceptance and to distance itself from the discipline of philosophy (Deutscher, 1970; Sampson, 1978; Jennings, 1986), psychology borrowed its research method from the physical sciences. Experimental methodology was to gain widespread acceptance in the field as noted by Colaizzi (1978):

> ..there is one point commonly upheld by all traditional psychologists. Regardless of their divergent and often opposing theoretical backgrounds, all would endorse the tenet that in order to qualify as genuinely scientific, psychological knowledge must be verified by experimentation or by some variation of this esteemed method (p. 50).

The domination of experimental methodology in psychological research has continued. Based on natural science epistemology, experience was subordinated to the world of theory and the subject matter of psychological investigation was subordinated to its method.

### 2.5.2 Implications of Traditional Research Methods for Psychology

Numerous authors have noted the peculiarity of psychology as a discipline in that, unlike the physical sciences, it chose its investigative methods prior to defining its content area (Romanyshyn, 1978; Colaizzi, 1978; Giorgi, 1970). By adopting the methods of

natural science, areas such as the nature and meaning of one's experiencing were eliminated from the subject matter of psychology.

McConville (1978), in the context of surveying how perception was traditionally investigated in psychology, observed:

> For natural science meaning is a sort of embarrassment because it resists reductive causal analysis. Consequently, traditional psychology for the most part has assigned meaning a secondary epiphenomenal status, treating it essentially as a by-product of the perceptual process (p. 102).

Conforming to the "core values" of industrial-technological society (Sampson, 1978), the main value of psychological research was to obtain control of variables. Colaizzi (1978) noted:

> Technological effectiveness provides the ultimate meaning of research and of what is to be investigated.... It just takes it for granted that good research results are synonymous with the discovery of manipulation by which control can be brought to bear on the investigated subject (p. 55).

Not only were the nature of research results taken for granted, but so were the very methods utilized. By accepting experimental methodology unquestioningly as the proper manner for doing rigorous systematic psychological research, an assumption of objectivity emerged and dominated. Rather than recognizing experimental methodology as reflecting one kind of

scientific attitude (Romanyshyn), it became accepted as the only way in which scientific work could be carried out.

Elaborate quantitative means were developed and utilized to demonstrate cause-effect relationships among variables from which general, universal laws were inferred. Yet because of the complexities involved in researching human phenomena, one gets a sense that although traditional psychologists uncritically accepted the notions of natural science, there has been a degree of discomfort with the actual achievements of psychological research, particularly in the area of counselling and psychotherapy. Horan (1980) contended:

> ...it is my belief that we find ourselves in the terribly embarrassing position of having proven far less than we purport to know. There is a quantum leap between our experimental literature and our methodological sophistication. We now know what is wrong with our data, but too many of us pretend to our students that there is solid empirical evidence behind our varied proclamations. Like the seers of ancient Greece we perpetuate our own Olympian myths with the most specious of arguments rather than admit our ignorance of the natural phenomena in question (p. 5).

He, however, stops short of questioning the basic presuppositions of experimental methodology.

A second source of discomfort can be inferred from examining the discussion sections of research papers and dissertations. One cannot help but notice the

amount of restrictions generally referred to in application of the results. What one can infer from the data is often very narrow. This is certainly strange for a system of research committed to discovering general and universal laws of cause-effect relationships among behavioural phenomena. What is discovered are general laws applied under severely restricted circumstances. It is these and other peculiarities that have brought many to question the merits of experimental methodology as being an exclusive or even relevant method for research in psychotherapy.

### 2.5.3 Limitations of Traditional Research

Critics of traditional research paradigms in psychology and psychotherapy have noted that research has generally failed to study meaning in human activity because of its utilization of methods that have downplayed and/or ignored the experiences of people (Kruger, 1983; Fessler, 1983; Smith, 1979; Colaizzi, 1978, Romanyshyn, 1974; Roche, 1973; Natanson, 1973; Giorgi, 1970, 1983).

Kruger (1983) observed how paradigms of inquiry utilized in psychotherapeutic research were contrary to the ways in which major figures in the world of

psychotherapy sought to understand its nature:

> It is a well-known fact that in the discoveries of Freud, Jung, Adler, Sullivan and Rogers and others, quantitative considerations played no part. These men were confronted by baffling problems which they sought to understand - not calculate. For them the primary givens were how they experienced their clients or patients, their personalities, problems and personal histories (p.8).

Kruger continued and described the direction which psychotherapeutic research took:

> Psychotherapy research seems to involve persistent and excruciating attempts to objectify and quantify experiential and behavioural data in order to isolate the variables that supposedly will make up what psychotherapy is, how it works and how effective it is. While the insights of the "founding fathers" occurred within the immediancy of their encounters with specific patients and clients, psychotherapeutic research seek their answers in an attempt to operationalize the concepts to psychotherapy in such a way that the holistic intuitive insights become broken up into discrete units amenable to measurement. However, it seems to me that certain basic questions regarding the researchability of psychotherapy have not been radically confronted in research within the measurement model that we have seen so far (Ibid.).

Fessler (1983) suggested that while it appeared that psychotherapeutic research seemed to have brought researchers and practitioners "closer to making sense of the talking cure," it has also left us with an understanding that is "so foreign to our lived experience of it" (p. 33). He noted that the type of methods that have been utilized have resulted in an

understanding based "on what the research procedures find we do," as opposed to what is actually happening. In viewing research as a process in which experience becomes translated into words and concepts that stand for what takes place, Fessler suggested that too much of what is important in the therapy experience is lost in a translation using traditional methods of research.

Yet research methods based on principles of objectivism, rationalism and logico-empiricism continue to be accepted by many as the only legitimate guidelines for doing scientific research in psychology. Subsequently many aspects of human experiencing have not been investigated because of difficulties in defining operational variables or other aspects of the experiencing which do not fit with traditional methodology. Noted earlier was that the concept of resistance was rarely studied empirically because of difficulties in operationalizing the concept.

## 2.6 Phenomenological Approach

### 2.6.1 Primacy of Experience

In contrast, phenomenological research approaches are based on the assumption that it is human

experiencing that we must study with a view to uncovering structures of meaning. Phenomenological research methods are dedicated to providing a human science basis grounded in experience for psychology and psychotherapy (Giorgi, 1970; Fessler, 1983; Kruger, 1983; Smith, 19789; Packer, 1985). The aim of phenomenology is to describe and understand how human beings attend to their different world-situated experiences in the course of everyday living. It is a method for revealing aspects of living taken-for-granted in our everyday attitudes toward what we do or observe.

### 2.6.2 Natural Attitude and Intersubjective World

Natural attitude is a point of view that human beings adopt in the course of everyday activities. It enables one to take the life-world, which is the world as encountered and lived in everyday life, for granted and to accept experiences as they occur. Roche (1973) added:

> ...It indicates that we must and do accept certain things as "real" in order to live and act in ordinary everyday life and it describes these "objectives" which include values and aesthetic features as well as facts and state of affairs, social facts as well as physical facts (p. 11).

The world of natural attitude is taken to be an

intersubjective world. It is not only my world but one that is shared by us. It allows for a common, communicative surrounding world to be constituted in which there is a practical interest. Schutz (1962) commented:

> In the natural attitude the world is not from the outset the private world of the single individual but an intersubjective world, common to all of us in which we have not a theoretical interest but a practical interest. The world of everyday life is the scene as well as the object of our actions and interactions. We have to dominate it and change it in order to realize the purposes which we pursue within it among our fellow-men. We work and operate not only within but upon the world... (p. 208-209).

Elsewhere Schutz contended that it was not belief that one suspended in the natural attitude but on the contrary he suspends doubt in its existence. He continued: "What he puts in brackets is the doubt that the world and its objects might be otherwise than it appears to him... (ibid., p. 229).

### 2.6.3 Suspending Usual Ways of Knowing

Schutz suggested that "phenomenology has taught the suspension of our belief in the reality of the world as a device to overcome the natural attitude by radicalizing philosophical doubt" (ibid.). Giorgi (1983) contended that achievement of a "proper access to psychological reality" involved the need for one to

bracket out usual ways (i.e. theoretical/empirical) one knew about a phenomenon so that one could describe it from a fresh vantage point. Giorgi explained: "One brackets what is known in order to experience more carefully and instead of enumerating the facts of the experience, the researcher speaks about how the experience presents itself to the consciousness of the experience, or its meaning" (p. 216).

By suspending one's usual way of knowing, one attempts to investigate the essence of experience as given to it by consciousness. It is through consciousness that the world and its objects are experienced and become meaningful. Consciousness is "active" and "productive" (ibid.) and how it attends to a given phenomenon is already influenced by sedimented meanings from previous experience in addition to the current situation.

In investigating experience with a view to uncovering meaning, one strives to clarify concepts as used in traditional scientific paradigms. In spite of its many criticisms of the natural science approach, phenomenology does not minimize the importance of the fact-world. A dialectical connectedness is recognized between fact and experience. Phenomenology in focusing on the essences of experience aims at a clearer

understanding of the fact-world. Sardello (1978) wrote:

> Phenomenology begins by discovering the ideas hovering above the facts and provides the possibility for more unbiased observation, or at least provides the opportunity for observation in which biases are known to exist so that the facts can be understood within the limitation of bias (p. 138).

2.6.4 Situation and Context

Phenomenological approaches stress that behaviour always occurs in a situation. Packer (1985) warned that "any act looked at in isolation from a situation is likely to be ambiguous to the point of opacity or obscurity" (p. 1081). Roche (1973) noted the implications of studying human phenomena out of context:

> Psychology deals with an abstract because it takes man out of society. Biologists can take fish out of water and when they are dead investigate them to explain how they live. The same is not true of psychology. It cannot abstract man from society - outside of meanings, purposes and life - and expect to understand his life (p. 173).

Packer suggested that "...we understand human action and act ourselves within a background of practices (bodily, personal and cultural) that is always present, although it can never be made fully explicit" (p. 1087). He continued:

> To attempt analytically to do away with this background and treat human acts as though they are

> object-like entities is a methodological error because it would be to remove the conditions for genuine comprehension of the phenomena being studied. Our interests and involvements, our habits and our cultural practices, play a constitutive role for the entities and events that we create and experience around us (p. 1087).

Romanyshyn (1978) provided a simple but enlightening example of how important context is to the understanding of human behaviour:

> As a final example of the importance of context to the understanding of human action, the reader should consider the following statements of action: (1) John kissed his father goodbye. (2) John kissed his girlfriend. (3) John kissed his boyfriend. (4) John kissed his boss Fred hello and goodbye (p. 44).

Romanyshyn observed that "within a perspective of naturalism a kiss is a kiss, the contact of two membranes" but "within the perspective of a human life, a kiss is a meaning which depends upon, among other things, to whom you give it" (ibid.).

### 2.6.5 Perspectival and Incomplete

Because the researcher's and participant's action occur in contexts reflecting their interests and projects, and in a particular socio-historical time, the understanding and descriptions generated in phenomenological research are perspectival and incomplete. Reflective and interpretative processes, major tools of phenomenological research, capture those

aspects of experience of interest to the investigator as influenced by one's interests, cultural orientation, and moment in history. Given the contextual characteristic of human action and observation, one can never rule out that an experiencing will be somewhat different in future situations. Yet phenomenology serves a crucial function in that it allows one to go beyond "our original unreflective understanding" (Packer, 1985, p. 1089) and reveal a world so taken for granted that we are rarely aware of its existence.

Herein lies the essential value of phenomenological approaches to research. In making human experiencing its subject matter, in utilizing tools for focusing on meaning and in revealing what is obvious in situations, it allows one to return to the roots from where one commences the journey for knowing about human action and experiences. A phenomenological approach can serve to free oneself from generally accepted and unreflected-upon attitudes of knowing that work to distance oneself from actual experiences. It allows one to return to experience and grasp it in a very human sense. It serves to remind the sciences that they originated from and relate back to the life-world.

2.6.6 Language

Spurling (1977) described the intersubjective nature of language as speech:

> ...In speaking we share a common, public, linguistic and cultural world. In speaking we participate in language, a cultural tool we're immersed in since birth.... Speech has a unique potential for reciprocity for through speech and listening to someone else speak we are able to take the role of the other to understand things from his point of view.... Speech can bring us the other as he sees himself and understands himself and to some extent as he is (p. 52).

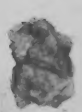
Bain (1985) observed:

> It (meaning language) provides the common ground through which two individual horizons can meet, transcend their individuality and create a shared world. It is because we exist in language that it has the power to disclose and reveal. Such is the power of language that it can lay open a world different from our own and yet allow us an understanding of that world (p. 28).

Schutz (1962) provided a phenomenological account of mechanisms for communication distinguishing between face-to-face communications and non face-to-face communications. Face-to-face communication was characterized in the following manner:

> ...he builds up the thought he wants to convey to me step by step, adding word to word, sentence to sentence, paragraph to paragraph. While he does so my interpreting actions follow his communicating ones in the same rhythm. We both, I and the other, experience the ongoing process of communication in a vivid present (p. 219).

As a speaker, one does not only experience what he



is saying, but also a "complicated mechanism of retentions and anticipations [that] connects with his stream of consciousness one element of speech with what preceded and what will follow to the unity of the thought he wants to convey". Likewise listener as interpreter also experiences a series of retentions and anticipations aimed at understanding the other person's idea. As long as the communication continues they share "a common vivid present, our vivid present which enables him and me to say we experience this occurrence together" (ibid.).

Non face-to-face communications are characterized by an inability for communication-receivers to utilize features as gestures, speech and observed meaning for intersubjective understanding. Consequently, people who communicate indirectly with each other understand each other through what Schutz referred to as ideal types. Spurling (1977) described:

> I apprehend my contemporaries (people living in the same society but whom I do not know) in terms of schemes of typification which impersonalize and anonymize them in terms of their functions or roles. Thus I do not need to know personally the man who connects my telephone calls or the man who delivers my mail. I only know them as types (p. 172).

Schutz emphasized that much of how people experience their social world is through types or

constructs and that scientific exploration of social phenomena is also made up of types but as Spurling noted "at a higher level of abstraction and formalization" (ibid.). He believed that the theoretical attitude needed to be dropped and that scientists needed to return to the world of everyday life for subject matter.

Titleman (1979) in discussing the implications of Ricoeur's existential phenomenologically-based philosophy for the praxis of psychology observed that the representations of experience and behaviour as lived in the world of everyday life emerged through language as discourse. Discourse was the necessary condition for meaningful experience and behaviour to exist. He cited Ricoeur in explaining why language as discourse in phenomenological psychology needed to be interpreted in the same way texts need to be interpreted: "...because language is metaphorical and because the double meaning of metaphorical language required an art of deciphering which tends to unfold the several layers of meaning" (p. 183).

Darroch and Silvers (1984) go one step further and suggest that the object of a discourse is "not to arrive at a process in order to present (the phenomenon) as substance, but to continually show our

way through the process" (p. 193). The objective of reflective discourse is not to "struggle for ultimate clarity or a reduction point for agreement" but "to elicit a dialogue between writer and reader" (ibid.) and inspire reflective thought.

2.6.7 The Giving of Meaning as a Reflective Experience

The act of giving meaning to an experience seems to take place after the event has already occurred. The process of providing meaning to an experience is a reflective act that interprets something in the past. Titleman (1979) pointed to experience as something that was "only available to the subject for description in the mode of memory" (p. 183). In memory a transformation of experience already takes place. Schutz (1962) suggested that acts do not take on meaning during the duration they are lived. He did not view meaning as something inherent in experiences that emerged within a stream of consciousness but "the result of a past experience looked at from the present now with a reflective attitude" (p. 210). Kocklemans (1973) questioned the very possibility of achieving genuine meaning of one's experiences in the world. He contended that actual meaning "remains hidden to empirical as well as descriptive methods" (p. 270) for

studying human experiences.

In his system of rational-emotive therapy, Albert Ellis offers a contrasting viewpoint about the origin of meaning given to a situation. In his conceptualization, meaning is already present in the process of one's behaving. Access is gained to meaning by examining the implicit thoughts and beliefs a person holds pertaining to that situation. In RET therapy, the objectives are to demonstrate to clients how they unwittingly choose to disturb themselves by the irrational beliefs (meanings) they hold about themselves and world originating events, to dispute those irrational beliefs and to replace them with meanings that enhance growth and effective living. Rather than meaning being hidden to empirical methods, the premise of RET is that exposure of personal meanings occurs by a style of questioning and challenging aimed at helping the clients reveal, challenge and replace their irrational belief systems.

### 2.6.8 Constraints to an Understanding of Phenomena

From the nature of phenomenological research, it could be misconstrued that understanding of any given phenomenon may be open to infinite ways of interpretation. In fact, there is not a total lack of

constraints on the different ways of understanding a given act. Packer (1985) stated:

> Our understanding of action seems rather like our perception of multistable figures; each act is seen predominantly in a few alternate ways, corresponding to the typical contexts of its occurrence. The action of handing a woman a flower may be a peace offering, a bribe, or a gesture of appreciation, but not (or usually not) a threat, the giving of advice, or the making of a dental appointment (p. 1086).

## 2.7 Different Ways in Which People Encounter the World

Phenomenologists have devoted their efforts towards revealing how men and women are meaningfully engaged in the world. Schutz's concept of Multiple Realities is an endeavour to describe manifestations of realities constitutive of everyday life. Viewed as particularly relevant for this investigation, a summary of the experience of multiple realities will be presented.

### 2.7.1 Multiple Realities and Finite Provinces of Meaning

Schutz (1962) believed that reality was constituted in meanings one provided to situations or objects and not in situations or objects themselves. Any situation or object could be bestowed with reality as long as it had a consistent set of meanings or what

he referred to as "finite provinces of meaning". Men and women were compelled to view any situation as real if their practical experiences revealed a circumstance as valid and its reality irrefutable. Although Schutz identified a number of different realities such as the world of dreams, the world of images, and the world of science as having finite provinces of meaning, he placed particular emphasis on describing those meanings which constitute typical reality for women and men, the world of everyday life. He viewed the following meaning - components as essential in experiencing the everyday world:

> (1) A specific tension of consciousness; namely, wide-awakeness originating in full attention to life.
> (2) A specific epoche - a suspension of doubt about the world not being as it appears.
> (3) A prevalent form of spontaneity, namely working (a meaningful spontaneity based upon a project and characterized by the intention of bringing about the projected state of affairs by bodily movements gearing into the outer world).
> (4) A specific form of experiencing oneself (the working self as the total self).
> (5) A special form of sociality (the common intersubjective world of communication and social action).
> (6) A specific time perspective the standard time originating in an intersection between duree and cosmic time as the universal temporal structure of the intersubjective world (p. 229).

A sense of reality about everyday life or other experiences remains intact unless some kind of "shock"

experience occurs that compels one to break through a particular province of meaning and shift an account of reality to something else. Schutz argued that problematic situations arise all the time forcing an individual to find other meanings to experience.

If we apply Schutz's analysis of multiple realities to doing psychotherapy, then we can make two important statements. The first is:

The world of doing psychotherapy can be and often is perceived as a finite province of meaning. Typical to the experience are settings of a particular physical nature (office) in which two or more people are engaged in a particular style of usually verbal interaction in which one attempts to influence the other within a time frame (45 or 60 minutes) and over a finite period of time (we are meeting together in order to solve a problem which will enable us not to meet together in the future). There are also particular communication and focus expectations (I as therapist will probe about your life and your problems; you as client are expected to cooperate in this venture).

The second important statement is:

In addition to common experiences applicable to most therapists, there are also orientations therapists take with them into therapy projects. At this level,

one can probably talk about multiple realities within the world of psychotherapy. Each orientation will have its own self-evident manner for guiding practice. Each orientation already selects aspects of experience which are relevant to it. Each orientation will be composed of elements internally consistent. Each orientation will have groups of loyal adherents that often bestow upon the orientation the sanctity of reality. The world of psychotherapy becomes experienced in a formalistic cognitive manner where loyal adherents to a particular orientation strive to preserve their particular guiding model.

## 2.8 Method of Research

The methods of phenomenological research are specifically structured for describing what is actually going on in human activity. An initial requirement is that the researcher has some kind of idea what people are up to in their behaviour based on experiences serving as a starting point from where gradual increases in understanding of the phenomenon occur.

The investigator attempts to obtain unbiased descriptions; that is, descriptions based on world-situated experiences. Because language is "allusive and elliptical" (Smith, 1979, p. 143) as normally

utilized, there is often a need for a number of interviews, conversations and/or written protocols, to achieve full and detailed descriptions.

The investigator patiently and systematically takes time to reflect upon the protocols and to interrogate the data. Smith (1979) describes reflective procedure in the following manner:

> The descriptive/reflective procedure is a discipline and a restraint. It imposes upon the researcher and therapist a slowness, deliberateness and caution. It requires that we move slowly, bracket our assumptions and allow the appearing to appear without the imposition of our stereotyped understandings. (p. 42).

Reflective interrogation of the descriptions is designed to allow meaning structures of experience to reveal themselves as remembered. In repeated and patient returns to the protocols and participants, one is able to attend to an increasing number of themes and meanings which are uncovered into consciousness. A richer and deeper portrait of the lived-situation emerges as aspects of experience are revealed and discussed.

An important aim of phenomenological methods is achievement of consensual validation; that is, that other readers agree that there is something meaningful about the completed project. Consensual validation is pursued by seeking descriptions from more than one

person, generally three or more participants on the subject matter. In this manner one can assess the degree in which different aspects of experience or theme are shared among a number of individuals or are peculiar to one or two individuals. Frequently not more than seven to ten participants are required for achieving a consistent profile of an interrogated phenomenon. By the seventh, eighth or ninth participant, themes are frequently repeating themselves.

### 2.8.1 Criteria for Doing Psychotherapeutic Studies

One of the major criticisms of research in psychotherapy has been that in attempts to operationalize different aspects of psychotherapy by the researcher, the very experience of psychotherapy had been violated (Kruger, 1983; Fessler, 1983; Smith, 1979). As noted in an earlier section, although we may have a more precise understanding of different aspects of therapy, the understanding is one which is generally foreign to our actual experience in the therapy project.

Psychotherapy is viewed by phenomenologists as a "series of encounters in which the life projects of two existences intersect and mesh" (Kruger, 1983, p. 27).

Kruger made the following point as part of his discussion about a new model of psychotherapeutic research based on phenomenological approaches:

> The basic problem of psychotherapy may be defined as how therapist and client are present to each other in this enterprise. However, this can be scientifically ascertained only by researching the problem of how therapist and client are retrospectively present to therapy. One way is for both therapist and client to explicate their experience immediately after each session. (Ibid.).

Fessler (1983) carried out a study where therapists with at least ten years experience and their clients were interrogated as to the nature of their experience from a five to ten-minute segment of a session held the day before and taped. In separate interviews, the therapists and clients were first asked to recall what had taken place. The tape was replayed a sentence or two at a time and subjects were asked to try and recapture what they were experiencing at the time. The results were intriguing. Therapists discovered what they thought they had done in the initial recollection was not what they had done once the tape was played back. Patients also found discrepancies between their recollections and reliving of the session. In the recollection they recalled less the content of their experience and more a global experience of being either understood or misunderstood

by the therapist. In reliving the session, the patient remembered that he had often been confused by what the therapist was saying. Fessler summarized:

> What the therapists thought their patients were saying and hearing was often not what the patients actually heard or intended to say. And what the patients thought the therapists were doing was often not what the therapists reported they were doing. Each often felt that he was being understood when, in fact, he was being misunderstood. In short, the findings reveal that what is expressed at any moment in therapy has meaning in adual context - the context of therapist and the context of the patient - and the meaning that they give to what is taking place is often quite different. (p. 41).

In a different study, Lipchik and Vega (1985) presented a clinical study of the treatment of a depressed client utilizing strategic methods. She presented the interventions she used in each session as well as a description completed retrospectively by the client of how he experienced the therapy. Like Fessler's study, the method was illuminating in showing the fit and lack of fit between what the therapist did and how the client experienced it. Treadway (1986), in an attempt to step outside his own subjectivity, devised a follow-up of some of his cases. He engaged the services of an experienced family therapist and had him interview several families after treatment was completed. As well, he interviewed Treadway to get his

views on each case. Treadway reported: "What we discovered was that there was very little match between the client's perceptions and mine." (p. 26).

In viewing the role of a therapist as a meaning-transformer in one's active encounters with clients, Barton (cited in Smith, 1979) identified five criteria for what he considered characterized a properly descriptive theory for psychotherapy:

> (1) a description of the theorist-therapist as meaning transformer of the situation;
> (2) a description of the way in which the meaning transformation becomes convincing to both therapist and patient;
> (3) a viewing that is as thoroughly attentive to, and descriptive of, the therapist as it is of the patient;
> (4) a detailed concern and investigation of the life-world meanings of the actual activities of both therapist and patient as they work together...;
> (5) all these descriptions must be open to consensual validation.

The study, particularly attentive to and descriptive of the therapist, did not include descriptions of experiences from the client perspective. The investigation should be viewed as an incomplete though essential first step toward a descriptive theory of particular difficulty in the psychotherapy situation.

## 2.9 Resistance and Experiencing of Difficulty

In examining the literature on psychotherapeutic resistance and the phenomenological paradigm for research, it became clearer that there was something fundamentally missing in the literature on resistance; namely, systematic and rigorous studies of the therapist's and/or client's actual experiencing of resistance, or particular difficulty in the therapy situation prior to its explanation in the taken-for-granted world of natural science. Occasionally, one can find isolated descriptions of the experience in a brief and superficial manner. However, they have been incomplete in their portrayal of the experience for which resistance serves as an explanation.

Meichenbaum and Gilmore (1982) noted that "every therapist knows those frustrations and worries that a creatively resistant client can release. The least and the most gifted therapists have each felt the irresistible resistances of the most dedicated clients" (p. 133). Basch (1982) wrote "when a patient cannot ally himself with us and is unable to step back from his own behaviour sufficiently to let us look together at what he is doing to himself we find ourselves frustrated in our therapeutic efforts" (p. 4). Anderson and Stewart (1983) observed:

> However well they know that resistance is to be expected, when they encounter it, therapists can become frustrated, insecure, or even actively rejecting of their clients.... Young or inexperienced therapists are particularly vulnerable to personalizing resistance interpreting it as rejection or as confirmation of their lack of skill.... Even experienced therapists can be vulnerable to or be trapped by the negative effects of resistance. While they may be somewhat less likely to take it personally, they often find that the cumulative impact of coping with ongoing resistance can result in a loss of creative energy and an increase in therapy fatigue. (p. 2).

Instead of providing additional descriptive information of therapists' experiences, these authors rapidly switched to theoretical and objective modes of understanding. Anderson and Stewart (1983) and Stream (1985) devote their efforts to explaining resistance and to suggesting methods for overcoming or mastering resistance. Studies of resistance; that is, of particular difficulty in a lived psychotherapeutic situation on the part of the therapist, have not occurred with an eye for examining how therapists construct the meaning provided to the experience. Viewed through the lens of theoretical models, an understanding of resistance is often consistent with one's adopted theory rather than one's experiencing. In distancing therapists from their lived-experiences, an important aspect of the psychotherapeutic situation may have been omitted.

I submit that this manner of knowing resistance has been incomplete for therapists for one of the essential aspects of the experiencing of particular difficulty or resistance in psychotherapy is that it is indeed a very personal experience. In spite of elaborate theories that have been developed for explaining and mastering resistance, one cannot point to a single rigorous account of the personal nature of its manifestations as defined and experienced by therapists.

## 2.10 Present Study

Given the inadequacies the literature has revealed for studying those experiences for which resistance serves as an explanation, the current study returns to the concept of resistance and proposes a descriptive frame for investigating and revealing its essential aspects in the form of particular difficulty. Therapist-participants were asked to provide open and nondefensive descriptions of situations where they experienced particular difficulty with a client.

A detailed account of the way in which the descriptions were obtained, and of the procedures followed in interpreting them, is given in the following chapter.

# 3. METHOD

## 3.1 Introduction

Prior to implementing this investigation, a pilot study was carried out utilizing two therapist-participants. They were asked to provide written accounts of situations when they experienced themselves being resisted in a therapy situation. After the tapes were transcribed into protocols and after reflecting upon the content, I returned to the participants and isolated areas of description which appeared to be in need of further elaboration. Descriptions were organized into self-originating and world-originating experiences. This was followed by an identification of themes for each subject, across subjects and a discussion.

The purpose of the pilot study was to test the research question for its ability to generate descriptive information, to test methods for obtaining elaborations in follow-up oral interviews and to obtain preliminary data for testing out methods of interpretative analysis.

The results demonstrated that the research questions were suitable for generating the desired

information. Given the propensity of therapists to use explanatory language reflective of conceptual influences upon their work, follow-up interviews were indeed essential for getting beyond interpretations and into essential descriptions. The follow-up sessions were effective for adding additional insights to the initial descriptions.

As noted in Section 1.3, the research question was a centre of discussion during the candidacy exam. Subsequent to that discussion, the research question was modified so that the focus of this investigation emerged to centre around an examination of particular difficulty in psychotherapeutic situations.

Although not focused upon during the candidacy exam, I found the method of descriptive-interpretative analysis utilized in the pilot study to be inadequate. In particular, the separation of experience into a world-pole and a self-pole was arbitrary and inaccurate for reflecting upon how one exists in the world. All experiences and all situations are world-originating, directing human beings to respond in a meaningful manner. As a participant in a situation, the life-world is co-constituted through the horizons that one attends to and through the meanings that one brings to a situation. One cannot separate a self from a reality

of being-in-the-world. Subsequently the method for analysis was revised to reflect the inherent unity of human experiencing. At the same time I recognized that as an interpretative effort, my biases remain part of what is uncovered from the very manner the research questions were posed, follow-up interview structured, descriptions organized, and themes identified in each situation.

## 3.2 Participants

Eleven therapists were asked to participate in the study. All agreed to take part. One participant dropped out because of her inability to actually sit down and do the initial description.

Criteria for Being Asked to Participate: In order to enhance the validity of this investigation, participants were required to possess a M.S.W. in clinical social work or M.A./Ph.D. in clinical or counseling psychology and at least five years of post-graduate experience doing psychotherapy. As well, I wanted to enlist therapist-participants from a wide spectrum of orientations and employment situations.

### 3.2.1 General Description of Participants

Eight males and two female therapists took part in

this study. The mean age of participants was 42.4 years with an average of 8.5 years of experience. Four participants held Ph.D.'s in counselling or clinical psychology, one participant held a M.A. in clinical psychology and five participants held M.S.W.'s in clinical social work. Employment settings and personal orientations varied. A short summary of each participant's background follows. Names are fictitious to protect the confidentiality of each participant.

(1) Debbie is a 37-year-old who obtained a M.S.W. from a university in New York City. Debbie majored in casework and group work and has thirteen years of clinical experience. This includes four years in a voluntary hospital, three years at an outpatient clinic for mentally retarded clients and one year working for a department of public health. Her main orientation is psychodynamic. At the time of this study, Debbie was employed as a primary therapist in an outpatient clinic serving primarily chronic psychiatric patients. The role of a primary therapist in the outpatient clinic is to coordinate all the services the client receives and to provide therapy. The primary therapist is part of a team assigned to work with the client. Other members of the team include the consulting psychiatrist who looks after the clients' medication needs and may

become involved in doing therapy and a case manager who is responsible for helping the clients obtain adequate housing, arrange financial help and become involved in workshop programs. The clinic is based on the medical model. The primary therapist is responsible for coordinating the case and record-keeping, the consulting psychiatrist has final word regarding treatment. The situation she chose was from this clinic. It will be referred to as D1 in the text.

(2) Larry (57) holds a Ph.D. in clinical psychology from a prominent university in New Jersey. Larry has a total of eleven years of clinical experience. This includes eleven years in private practice and four years working in a community mental health clinic. Larry's areas of specialization are children and adolescents. He presented his major orientations as systems and behavioural. Prior to becoming a clinical psychologist, Larry worked many years as an electrical engineer and in public relations for I.B.M. His case was chosen from a private practice experience. The case will be referred to as D2 in the text.

(3) Peter (45) holds a M.S.W. from a university in New York City. Peter's major was in clinical practice and his major orientations are family systems

and Erik Erickson's Life Cycle. He has a total of six years experience in clinical work including three years inpatient and two years outpatient at a psychiatric hospital and one year as a counsellor at the YW/YMHA. As well, he has developed a part-time private practice over the past five years. Currently he is employed in an outpatient clinic of a psychiatric hospital. His presentation was chosen from among his cases in an inpatient facility and will be referred to as D2 in the text.

(4) Tom (46) holds a Ph.D. in clinical psychology from a university on Long Island, New York. His major is in clinical practice and his main orientation is psychodynamic. Tom has a total of seven years experience in clinical work including two years at a rehabilitation centre for the mentally deficient and five years at community mental health centres. In addition, he has developed a part-time private practice over the last five years. He is currently employed at a community mental health centre. The structure of community health centres are somewhat different than outpatient clinics. Like outpatient clinics, the consulting psychiatrist must place his or her signature on all treatment plans. However, the therapist works in a more autonomous fashion. Besides the intake

meeting, the psychiatrist will only have contact with the client when necessary. All the therapy is carried out by the therapist. Community mental health centres serve clients who are less dysfunctional than outpatient clinics. They generally do not employ case managers. The therapist spends most of his time doing therapy. Tom's presentation was chosen from among his experiences in the mental health centre and will be referred to as D4.

(5) Saul (32) holds a Ph.D. in clinical psychology from a university in Rhode Island. His major was in clinical and community systems psychology. Saul's major orientations are psychodynamic and family systems. He has a total of twelve years experience including one year at a university counselling centre, six years at an alcohol unit and the past five years in a community mental health setting. Currently he is employed in a community mental health service and has a part-time private practice. His case was chosen from among clients he had seen in the community mental health setting and will be referred to as D5.

(6) Bob (43) holds a M.S.W. in social work from a college in New York City. His major is in social work administration and he presented his major orientation

as behavioural and medical. Bob has a total of five years experience including one year at a rehabilitation centre at a psychiatric hospital and four years in an outpatient setting. He stated his area of specialization was with chronic psychiatric patients. Bob's example was chosen from among his experiences in an outpatient psychiatric centre and will be referred to as D6.

(7) Sandra (35) holds a M.A. in clinical psychology from a university in North Carolina. She majored in clinical work and her main orientation is eclectic. Sandra has a total of ten years experience including five years in an inpatient ward in a psychiatric hospital and five years in an outpatient clinic working with groups. Sandra's case was chosen from among her past experiences in the outpatient clinic and will be referred to as D7.

(8) Ken (44) holds a M.S.W. from a college in New York City. He majored in social work and his main orientation is family systems and client centered therapy. Ken has a total of ten years experience including four years in a psychiatric hospital (two years inpatient and two years outpatient) and six years in a community mental health setting. Ken's presentation was chosen from among his past experiences

in a community mental health centre and will be referred to as D8.

(9) Arnie (44) holds a Ph.D. in humanistic psychology from a university in Connecticut. He majored in children and counselling and his major orientation is cognitive-behavioural and Rogerian. Arnie has a total of twenty-two years experience including two years in a residential setting for adolescents, three years with emotional children, three years in an outpatient psychiatric setting and fourteen years in an inpatient psychiatric setting. His case was chosen from among his experiences in an inpatient psychiatric centre and will be referred to as D9.

(10) Mike (34) holds a M.S.W. from a college in New York City. He majored in individual psychotherapy and group work. His major orientation is group. Mike has eight years experience including two years in a community mental health centre, two years in an inpatient psychiatric hospital and four years in an outpatient psychiatric hospital. Mike's example was chosen from among his experiences in an outpatient intensive day treatment program and will be referred to as D10.

See Table 1 in Appendix 3 for employment summary and Table 2 in Appendix 3 for orientation summary.

3.3 Method

Potential participants were oriented to the philosophy, objectives and method of this study through a short introductory paper I prepared and distributed. Those who consented to participate were asked to provide written accounts of their memory of experiencing of ongoing difficulty in a psychotherapeutic situation. This method of data gathering provided participants with the opportunity to generate descriptions through situations which they themselves identified as being relevant to the problem at hand. As Burbridge (1977) suggested, the use of situation allows the participant, not the investigator, "to determine the beginning and end of what he had lived through". It also provides for explicit recognition that it is in a situation that phenomena "originate and are lived" (p. 84). In Appendix 2, Debbie's written descriptions of her work with Janet is presented.

The next step was to begin to reflect upon the protocols. I read and re-read each protocol with the aim of uncovering initial meaning-components and with the aim of identifying aspects in the written accounts that were unclear and needed further elaboration. For example, in Debbie's written account, she wrote:

> ...What I did find frustrating were the changes in her personality which eventually became predictable but which always felt like receiving a curve ball.

I asked myself questions like what did she mean by "find frustrating"? How did she experience being frustrated? What did she mean by "receiving a curve ball"? "How did she experience receiving a curve ball"? "It seems like she is referring to Janet's inconsistent behaviour". "In what way did she experience the inconsistent behaviour"? "How did it affect Debbie"?

I proceeded to interrogate the written descriptions in this manner. I marked the text areas about which I wanted additional information and wrote out the questions I intended to ask in the following interview.

Within a maximum of three weeks I returned to each participant for a taped interview. I asked the participant to begin reading from a typed copy of the original description. This method was a modification of the approach utilized by Burbridge (1977) in his investigation of the experience of being frustrated. It was chosen to help the participant re-orient to the protocol situation. Participants were asked to stop at points in the text which I had earlier marked and I

asked questions for purposes of elaboration and clarification. I turn to Debbie's text to exemplify the process of the interview in the follow-up. The section asking Debbie to elaborate on her statements regarding frustration and "receiving a curve ball" is presented.

I: Let me stop you here. Tell me a little bit more...you found her frustrating and you said it was like being on the receiving end of a curve ball. Tell me a little bit more about how you experienced that.

D: Well, I would begin to think that we had a relationship and that perhaps she would call me when she got into trouble or she wouldn't do some of the things that she did just because of the relationship, and I found out that the relationship had no influence on her behaviour.

I: What kinds of things do you recall saying to yourself in face of this frustration? Any kinds of body reactions, tensions, or anything like that?

D: Well, I think when I would get angry with her I would just kind of distance myself from her. I would get more formal, less sort of buddyish and I would sort of step back into the role and be more formal when I got angry. What else do I do? All sorts of terrible thoughts (laughs).

I: Do you remember what kinds of thoughts?

D: Well, I began to think that she had no conscience and that really bothered me. I guess she touched off things that tend to be my pet peeves, which are people that have slightly sociopathic behaviour. I mean, that is a term, but when you deal with someone, you see they really don't have a conscience. I mean, nothing really bothered her and that lying didn't bother her at all and that bothered me. I don't want to have a lot to do with you if you're going to lie. Not so much to me, but

to other people.

I: You said, "sometimes I got really angry when she was like that". What was it like feeling angry?

D: It didn't bother me. I just knew I was angry and I would talk to somebody about that and...I would mostly go and talk to the case manager and tell him how angry she was making me. I would also talk to the psychiatrist but the psychiatrist seemed to feel that she was doing all right because she was taking her medication. I mean, she seemed to see her in more of a positive light than I did. She was complying with the rudimentary parts of treatment, which is that she was keeping appointments with her and she was taking Prolixin shots.

I: Were you able to feel your anger anywhere in your body like a flushed sensation or...?

D: No. (Continues to read) She is then very appreciative of help and I felt that I was beginning to have a trusting relationship with her. However, within the next week, she could become very angry, hostile...towards me and the so-called relationship I thought I had with her meant nothing.

Debbie began to clarify how she felt when she was at a receiving end of a curve ball. I did not find her response sufficiently illuminating and I returned to this aspect of the experience later in the interview.

Sometimes responses were not connected to my question although important information did emerge. An example was Debbie's response to my question about some of the things she recalled saying to herself in face of her experience of frustration. Her initial response related to what she remembered doing in dealing with

the frustration. Initially she seemed to respond to her own anticipations and understandings. However, at the end of the response she stated: "What else did I do? All sort of terrible thoughts," apparently re-orienting herself to my question. I utilized her statement to follow up and repeat the original question, which Debbie then responded to directly.

At times the elaborated descriptions would be unclear or insufficient and would be in need of further clarification. My questions in these situations would be spontaneous and aimed at increasing an understanding of the particular aspect. With Debbie, a short second interview was done as I continued to be unsure about how she experienced her value judgments as being positive and enhancing in the situation. The complete summary of my follow-up conversations with Debbie is presented in Appendix 3.

### 3.4 Data Analysis

After a transcript was transcribed, I read and re-read the transcript on several occasions to gain a sense of the wholeness of the experience and to start identifying meaning-components. In the process I re-wrote each protocol combining the written descriptions and elaborated transcript. The purpose of re-writing

was two-fold: to reduce the material to one manageable document and to gain closer proximity to the essences of the experience for the participant. The participants' own words were utilized to the maximum in the re-write, which is in keeping with the intent of descriptive studies.

Each re-written script was examined and identified meaning-components were marked off. Examples of meaning-components were then re-written under thematic headings. The repetition of a meaning-component was not required for a particular description to be considered a characteristic of a participant's experience. Approximately five to nine meaning-characteristics were identified in each script. As I went through the scripts, I began to note which themes were common to two or more participants and which themes were unique to that particular participant. Six themes were identified as being common to all participants while ten additional themes were identified as being unique to some but not all. In the following chapter, two cases are presented to provide the reader with a sense of the wholeness of participant experiences and to contrast those experiences as to their shared meanings and uniqueness. This will be followed by a summary of general and specific themes

identified from examination of all ten scripts.

While the findings do not represent an exhaustive uncovering of all meaning-components, they do represent a step toward increasing our understanding of the essences of the experience of particular difficulty in therapy. They also reflect the meanings and interests I brought to the interaction with the participants and their descriptions.

We turn now to the case studies and summary of general and specific themes.

# 4. DESCRIPTION OF THE EXPERIENCE

## 4.1 Presentation of Two Cases

Debbie's description and Peter's description were chosen to illustrate the holistic nature of therapist experiences. The two cases were chosen from the ten available cases because of their contrasting nature. While they shared characteristics that were common, there was also profound differences in how each experienced particular difficulty in their situations. These two examples demonstrated for me the wide range of possible meanings that could be given to an experience of particular difficulty.

### 4.1.1 Summary of Debbie's Presentation

Debbie, it will be recalled, had worked in different settings and was employed as a primary therapist in an outpatient clinic serving primarily chronic psychiatric patients. She chose the case of Janet, a 27-year-old female for whom Debbie had provided therapy services, from her experiences at the outpatient clinic.

In introducing the case, Debbie provided contextual information about the nature of the clinic

where she was employed, about the kind of clientele she perceived as attending the clinic and about Janet's previous experiences in therapy. For example:

> The clinic is an outpatient unit of a state psychiatric hospital.... The focus of the clinic is to treat the more chronic clients in this county and that often translated to mean the clients with less motivation for treatment - in general, less financial and emotional stability in their lives.... She has been in psychiatric treatment since age 16.... She had been treated for more than three years and was no longer keeping appointments or complying with treatment.

Debbie recalled that her first impression of Janet had been sympathetic. She had been sensitive to what she perceived as Janet's feelings of being rejected when transferred from the county clinic to the state outpatient clinic. Debbie reassured her that she was willing to work with her. Initially, Debbie experienced a trusting relationship as emerging through their contacts. During a two month period, Janet had been victimized on a number of occasions including a break-in to her apartment and being physically assaulted by different males. Debbie recalled that Janet would confide in her about those experiences and abut her fearfulness of people. Janet was initially "willing to follow through on suggestions and she [was] then very appreciative of help". Debbie projected that

a trusting relationship had developed which could be used by Janet as a vehicle for staying out of the kind of trouble she had been getting into.

Gradually, Debbie came to experience herself as repeatedly being on the receiving end of a "curve ball". Although Janet presented herself in therapy as someone who "would talk to me very sensibly," "show some insight into things" and "sort of sound good," Debbie learned that Janet's behaviours in everyday situations were not consistent with her self-presentation in therapy. In contacts with counselors from her residence, Debbie discovered that Janet was constantly fighting and breaking household rules. When Debbie confronted her about the complaints, Janet attempted to present herself in a positive light and lied about the actual details. In Debbie's words:

> I saw that Janet lied repeatedly about her behaviours. She also lied to me in therapy. She broke the rules and denied breaking them. She lied and denied. When confronted with it, she would lie and turn the whole thing around.

Debbie felt "foolish...going out on the limb for somebody who was used to lying" and ultimately Debbie's experiencing of Janet transformed itself from a belief that Janet wanted to be helped and that Debbie could help her to a belief that Janet was a lying, deceiving individual whose behaviour was beyond help.

Debbie experienced herself as becoming increasingly affected by Janet's behaviour. Frustraton, anger and helplessness characterized her experiencing of Janet in the relationship. Debbie described her reaction to Janet's behaviour in the community residence in the following manner:

> I was angry at her. I thought she was acting more like a three-year-old in a 27-year-old body and wouldn't accept it all so she turned everything around so she had no part in it.... I got annoyed. It was a coward's way out...

The making of different value judgments about Janet's behaviour, attitudes and decisions became common for Debbie. She stated:

> I began to think that she had no conscience and that really bothered me. I guess that she touched of things that tend to be my pet peeves which are people that have slightly sociopathic behaviour... I really felt she got what she deserved....

In describing her reaction to Janet's decison to have a tubal ligation, Debbie remembered:

> I felt in some ways that was a responsible decision on her part but again with that I also felt it wasn't responsible. I felt it was an easy way out of her just wanting to be promiscuous so I did have value judgments on that but with that I went to talk to the psychiatrist and we talked a long time about it...

Drawing from her orientation for doing therapy, Debbie concluded that Janet's behaviour was evidence that Janet lacked the necessary psychic structure for

engagement in therapy. In Debbie's words:

> There was no personal core there that I thought would help her to start developing insights into her faults. I began to think that she had no conscience. She continued to use mechanisms of projection and denial in her dealings with others and often seemed to have no conscience.

Subsequently, Debbie drew a distinction between aspects of Janet's behaviour such as her paranoia and fearfulness, which she viewed as being caused by her mental illness, and aspects of her behaviours such as her acting-out and lying routine which Debbie contended was a function of her "personal code of ethics [which] allowed her to lie, throw temper tantrums and essentially do anything she felt to get her way". Debbie asserted that often Janet's behaviour "bordered on the criminal," and that at times it could be more effective to treat her as someone who broke the law as opposed to being treated as a psychiatric patient. She stated:

> She should really be treated more as somebody who was breaking the law than as a psychiatric client for I didn't see it as anything that had to do with her illness.... I didn't find her more flexible or willing to listen to another way, but rather saw her stuck in a groove which was comfortable and which she had no motivation to change. She has been personally arrested and spent a few days in jail, but her family bailed her out. I think she will be there again and may finally decide to change on fear of repeated punishments like that.

An additional feature of the experience was

Debbie's assessment of not gaining any influence over Janet's behaviour. The following conversation between Debbie and myself exemplified her sense of powerlessness and frustration:

I: You've mentioned the term frustrated a lot. It seems like it has been a major part of your experience with this girl was the frustration. How did you know in this particular case that you were feeling frustrated? What kinds of things were going on for you?

Debbie: Um, I would get a phone call from the community residence telling me about this, this, and this, and I would be really upset to hear all of this, of what she had done and that is how I would know that I was frustrated.

I: When you say upset....

Debbie: Do you mean like do I feel it in my body, upset?

I: Yeah.

Debbie: My voice gets louder and I sigh and I, it's sort of a feeling of resignation, you knnow, ach, not again, powerlessness. I can't help you. I can't do anything to change her so don't look at me. I know I am her therapist but I can't help it.

Debbie continued to maintain a relationship with Janet because of what she viewed as being the role of a therapist. She did not like many aspects of Janet's behaviour and she clearly states that in any other situation she would not have continued in a relationship with her. In her words:

> I mean, nothing really bothered her and that lying didn't bother her at all and that bothered me. I don't want to have a lot to do with you if you're going to lie.

In responding to my query about the uniqueness of the difficulty in this situation, Debbie observed:

> Well, I think the fact that she is a client you have that responsibility to keep on having a relationship to somebody whom you may not like after a while or you may disapprove of things whereas if it was just a regular person, you probably wouldn't have a whole lot to do with them. The fact they are a client, you have to keep on in this relationship.

To deal with her feelings of frustration and anger, Debbie distanced herself from Janet. She recalled:

> I think when I would get angry with her, I would just kind of distance myself from her. I would get more formal, less sort of buddyish and I would sort of step back into the role and be more formal when I got angry.... I distanced myself. That's what I did. So I think that is what happened. I got frustrated and so I distanced. The last two months that she was at the residence she was not doing well but I wasn't seeing her that often because I knew it would just lead to a discussion of how it wasn't her fault and I just felt that I couldn't so I backed off a bit.

Elsewhere, Debbie commented how distancing was a typical way she handled situations or people she was frustrated with:

> Similar, it is very similar. I usually get minor frustration and I end up complaining about the situation and it usually takes a while until I get some objectivity about what is going on. I tend to distance when I get frustrated with the people. That's a real way that I deal with frustration. I'll back off from the person so it

> is really typical of what I do. I sort of talk-to who I can and distance from the person who is annoying me.

Debbie's experiencing of Janet wasn't all negative. Debbie occasionally experienced herself as being hopeful that Janet could change. She pointed to her impressive demeanour during sessions as influencing Debbie to have second thoughts for a short period of time:

> I think the unique part of it was her ability to sort of be a nicer person at some times with me so I would get hooked into thinking that we could do a little change here even though most of the facts showed that you couldn't. Whereas with other clients where you can't, you don't see too much glimmer or hope that you could so that you don't get too much frustration. I think that with her, her intelligence, her humour, you know, something that looked like, gee, maybe she can get herself together! As I saw all those kinds of good things, she just kept going downhill in terms of her behaviour.

Debbie recalled being influenced by Janet's physical appearance. When Janet came to session and looked attractive, Debbie approved more of her. When she came to session and looked unattractive, Debbie was more disapproving. Debbie often experienced Janet as unattractive when she knew Janet was lying to her or had done something wrong. She remembered:

> It's interesting, well, it's interesting. Often when she would come in and report something to me and I knew she was lying or I knew she had done something that was vaguely illegal or violent I thought she looked really bad. I thought there was something really negative about her appearance

> and she had very short hair. She would crop it very short so she almost would look like a boy and there was just something down-and-outish about the way she looked. When I approved more of her, sometimes I thought she was attractive. She had sort of a flamboyant way of dressing. She dyed her hair orange. She could look almost...well, sometimes there was almost something diabolical about her appearance to me.

Debbie's awareness of her own bodily involvement was of her voice taking on an angry, whiny tone when dealing with Janet and of her need to walk "here and there" and "to repeat things about three or four times" to whomever would listen.

The sessions were terminated while Debbie was on vacation. Janet had left the community residence and had nowhere to live. The case manager on Debbie's team wanted to refer her to the crisis residence on the hospital grounds and Janet refused for fear of being re-hospitalized. Instead she chose to see a private psychiatrist and stopped coming to the clinic.

### 4.1.2 Summary of Peter's Presentation

Peter, it will be recalled, was employed in an outpatient clinic at the time of this study. However he chose to exemplify his experiencing of particular difficulty through a description of his experiences working with Kathy, a 30-year-od female patient, in an inpatient psychiatric centre. Like the outpatient

setting, the structure of inpatient wards are based on the medical model. The professionals work in teams and the consulting psychiatrist carries the ultimate responsibility for treatment. A major difference is that patients reside in locked wards and must earn their privileges to spend a few hours a day away from the ward by demonstrating appropriate behaviour as defined by the team. The patient must remain in the hospital until she or he is deemed ready for discharge by the treatment team.

Peter introduced the case by revealing theoretical concepts through which he envisioned Kathy's difficulties. He disclosed:

> The patient in queston that I had so much difficulty with was a woman about thirty years of age who, as best as we could determine, was borderline personality disorder and this was my first experience with someone of this nature. I had some theoretical work that I had gotten into with borderline, some reading, and basically learned they are one of the most difficult clients to work with and you very frequently don't know where you are with them and one of the most significant things for the therapist is to realize that the tremendous pulls and tugs that they experience from their client is one of the very signs they have a borderline patient on their hands.

Kathy revealed herself to Peter as someone who viewed Peter as "all good or all bad," as someone who was "capable of intense rage and would lash out verbally in the most vile language," as someone who was

a distrusting person, and as someone who presented herself as a dependent, crying, demanding person. She was described as someone whose emotions swayed frequently and in an extreme manner. In the first therapy encounters of this situation, Peter experienced himself as being confused, of not being in control and of having no direction, particularly in the face of Kathy's sudden verbal assaults:

> ...At that time it was like, I don't believe...what the fuck are you going to do with this? You can't do anything with this, nothing! It is impossible because no matter how it is expressed as long as it comes out...no, wham, it is that fast! Good grief! What the hell do you do with this? This is something that I don't know anything about and I know that this is different from all the others I have dealt with so far. This is new stuff and other stuff, it is not working.

Peter further illustrates the difficulties in working with Kathy through the following story:

> ...and you remember you passed the farmhouse and you say, gee, I don't know. Well, I'll give it a shot, and you start walking back and you start talking to yourself about how this is not going to work out. This is not going to work out. This is not going to. And that farm, I'm going to go up there and knock on the door and I know it, and you keep reading into this thing how you're not going to get the jack you need. You finally knock on the door, he opens the door and say, yes, and you say, keep your fuckin' jack!

Although experiencing a lack of control, a lack of direction, and at times, a desire "to scream at the intolerance she seemed to show" Peter fought

against his own impulses to react to the here and now of the situation:

> ...It was very disconcerting to accept the tongue-lashing so vehemently offered and at the same time maintain objectivity, be there for her next time and not lose hope! How to get a gestalt of this who actually experienced life in this way and with that to be able to be empathic to her changes so that my own countertransferential reactions were not determining of what I did with her.

Peter ws determined not to respond to the moments of her mood swings. Instead, he recalled investing his effort into finding an effective way to work with Kathy. Scanning the written literature about borderlines, Peter was not successful in discovering ideas that would be useful for him in the project. He cited that most of the literature was found in an orientation that did not fit for him. He described:

> This was a couple of years ago...about three years ago...and much to my chagrin there wasn't very much information around. In fact, people were still debating where borderline comes from. And I'm talking about giants in the field debating what the essence of borderline is and how do you treat it. The gist of the material I read was psychoanalytic in nature and that was not a place I was coming from.

Peter noted how the world presented him with an opportunity to come in contact with practical information through a random meeting at a workshop with someone whose main interest was borderlines. This individual revealed ideas Peter was able to identify

with and to incorporate in his work with Kathy:

> ...I read her stuff and I gave her a call and we talked occasionally on the phone and it gave me kind of a chart and a direction and more importantly it told me what not to do and the principal thing she said was, watch out for a hospitalized borderline because they turn the hospital into the famiy and they never leave and that is the most dangerous thing for the borderline.... The second thing I picked up which really helped me a great deal was to accept the rages and to allow them to work themselves through.

Peter accepted the expert's approach as the way to proceed. His objective was to have Kathy discharged from the hospital as soon as possible. Furthermore, he became much more accepting of Kathy and her mood swings and no longer measured his own effectiveness as a therapist by his ability to keep them under control. In his words:

> ...I accepted her as she was about ninety-nine percent of the time. I got really pissed about one percent of the time and was really concerned more of, with all of this going on, what kind of effective help is she getting in this process and in hindsight I can say it was my constancy which is what I knew she needed.... ...And in essence that helped me with my own expectation of if I'm an effective therapist, then I'll be able to control the rages. If I can establish trust, if I can share empathy without producing a fear of engulfment, then I'm a good therapist for this patient and she won't have to go through her rages. Well, not having that burden anymore gave me a great deal more flexibility and in a sense I was allowing the client to be more who she was, accepting that and just moving right along in a steady course toward discharge.

A main source of Peter's being affected was related to his experiences of other professional personnel and how they reacted to Kathy. Note the following dialogue between Peter and myself about how many of the psychiatric residents responded to Kathy:

I: How did other staff react to these kinds of behaviours? What did they do?

Peter: They wanted to kill her.

I: Her doctor, TA's?

Peter: Well, we had a series of doctors who were psychiatric residents. Depending upon their responsibility, they had different reactions. Those people that needed to be liked by the patients hated her because there was no way.... She sucked you in by saying, oh, you're so nice! That staff member couldn't take it, really began to hate.... Sure, hate the patient because that is the kind of patient that doesn't give you what you want if what you want is approval. She is constantly shifting and it is not based on what you are doing half the time.

Later on, Peter expanded and explicated how a hospital setting was not conducive to his client's well-being:

> Her stuff, her pathology in a sense gets fed at the hospital in a very precarious way. The hospital can't avoid it. There's no way it can change itself. I think also, the borderline is so destructive to the functioning of the hospital, that she generates a tremendous amount of anger which doesn't do her any good.

Peter felt frustrated about his inability to convey to other professionals the sense of confidence

he had about Kathy. He interpreted the repeated rejection of Kathy by community residences as a sign that places were searching for reasons to reject her. Peter resented this and let others know:

> It wasn't easy and it was very frustrating at this end where I was always looking at her baseline and trying to ignore her shit and I couldn't really convey that to people in a way that would give them a sense of confidence. They were only interested in, give me a reason to reject you, go on! And there's a lot of shit like that and I really resented it and I let poeple know.

Uniquely characterizing this experience was that Peter felt stimulated and challenged in the situation. He viewed other therapists' rejection of Kathy as particulary appealing. He stated:

> I must admit that there was something that appealed to me about having a client like her and that was that nobody wanted to go near her therapeutically. They literally didn't want to have anything to do with her. I think that kind of a challenge I enjoy. I think it is a matter of being a perosn of last resort and also provides me with the opportunity of really working by instinct using a lot of intuition....

Peter continuously questioned the extent of his effectiveness and whether his expectations were being met:

> Well, what is she getting out of this clinically? With all the ups and downs going on, where is the baseline? What's important clinically is where the baseline is moving. Is it moving in an overall more secure, less dependent manner?

Peter reported the project was never completed as

he accepted a positiion in a different agency. In the process of preparing Kathy for termination, Peter thought that their disengagement could be disruptive for Kathy as past information about Kathy indicated that she experienced difficulties in circumstances of separation and was intolerant of loneliness. In wanting to terminate in a way that would be least damaging for Kathy, Peter deviated slightly from his typical actions in the termination process by accepting a couple of telephone contacts with her.

> She called me and I came back to the hospital to be there and I ran into her. She called me at home a couple of times. How are you doing, how are you doing? Gee, could you come up and visit me? All that type of thing. She had got this problem and that problem and how are you doing? (voice raises) Oh, I'm doing all right, same old stuff and then she would rattle off a few diatribes about this fucking cocksucker and that and so on and we'd have a little chuckle and a little laugh and so I ask the same old stuff for you, right? And I'd say, yeah, you hanging in all right? Yeah, I'm hanging in all right. Okay, good. If I'm up there and I have the time, I'll come in and see you . And there were two or three of these and that was it.

In the postscript, Peter questioned the very die in which Kathy had been cast; that is, whether she was in fact "borderline". He recalled that Kathy had successfully maintained a ten-year relationship with a man, which was very unusual for someone who was, in fact, borderline. Queries were raised about the

effectiveness of a medical model for helping Kathy and about what a non-medical person can do in a very medically-oriented kind of facility. He reflected:

> As I think back on her, I remember that as a borderline client, the fact that she was able to maintain a ten-year relationship with this man who himself was not a winner but that's not the point. The prevailing notion is that borderlines are incapable of maintaining any kind of long-term relationship with anybody so I always questioned whether she was really in fact borderline and of course she had the usual paranoid schizophrenic diagnosis.... It's one of those clients where a medical model of diagnostic category and the treatment doesn't necessarily follow all the way. We find that most of our borderlines are refractory to medicaton. They are of short-term use at best. There's an interesting case of what do you do as a non-medical person in a very medically kind of facility in which K was. That was a place where the psychiatrists decided what would take place in therapy.

### 4.1.3 Summary of the Two Presentations

What clearly stands out in these two case presentations are the differences as to how each characterized their experiences. Debbie experienced tremendous frustration and anger toward Janet as the sessions continued. Debbie became judgmental and experienced moral indignation toward some of Janet's behaviours and decisions. She appeared to feel very uncomfortable in the situation. In contrast Peter increasingly felt good in working with Kathy. He experienced the situation as stimulating and

challenging. He joined together with Kathy achieving a consensus with her about working towards discharge. What he experienced as frustrating and irritating was in how other professionals experienced Kathy and their unwillingness to give her a chance. A major difference in how they characterized their experiences may have been a function of the different orientations each therapist brought to the situation. This will be discussed in section 5.3.1.

## 4.2 General Themes

The six characteristics identified as being common to all participants were: (1) being frustrated, (2) experiencing particularly strong emotions, (3) experiencing uncertainty in their actions, (4) not being effective, (5) struggle and distancing, and (6) experiencing the situations as extremities.

An elaboration of each theme follows.

### 4.2.1 Being Frustrated

All participants identified frustration as a major characteristic experienced in the situations as remembered. In D1, Debbie recalled being frustrated by Janet's temper tantrums, repeated lying and manipulative behaviour. Debbie felt like she was

receiving a "curve ball" from Janet, never knowing what to expect from her in or between sessions. In Debbie's words:

> What I did find frustrating were the changes in her personality which eventually became predictable but which always felt like receiving a curve ball.... Let me see, the first really frustrating thing that happened was she had no place to live. I placed her in the crisis residence. She broke the rules and denied breaking them. She lied about breaking them. She ran away from there . She just didn't...she did terribly and she came back and she wanted me to advocate for her. She told me they were lying and that she hadn't done a lot of this stuff and I went to the meeting with her present and it became very clear how she dealt with people when she was confronted. She lied and she denied and she did this at the meeting and I saw that we were getting nowhere.... So I saw that I was working with someone who might come in and sort of sound good but out in the world did not do well at all. I think the lying aspect of it was what really bothered me about her.

In D2, Larry recalled the sense of frustration he experienced in working with Norma, a young teenage female, and her parents, Mr. and Mrs. R. Larry became particularly frustrated over Norma's uncooperativeness and rotten behaviour. He also experienced Mr. and Mrs. R's attempts to place pressure on him to come up with instant solutions for Norma as very trying. Note the following statements about Norma and her parents:

> I felt that she didn't cooperate willingly in the therapeutic process. I was very aware about how angry and frustrated I was getting. She basically was, I would say, the most difficult kid to work with, not that I hadn't had problems that sounded

> like her but the kids were sometimes a bit more cooperative and I really was feeling very frustrated with that. I gave her some tasks to do and she would not do them.... There were occasions when this child refused to come to my office for therapy.... The child was very demanding.... She was constantly testing me in therapy to see if I was going to get angry at her and reject her like everyone close to her had.... The main thing that made this difficult was that the child of course was not cooperative in therapy.... Even though Norma acknowledged she had problems with anger and you could get her to admit that she didn't go to school, she wouldn't cooperate very well. She wanted to change the conversation. She wasn't going to do anything....

In D4, Tom expressed the sense of stuckness he experienced in working with Connie, the teenage daughter of Mr. and Mrs. T. Frequently he thought a trusting relationship had emerged only to discover that Connie had withheld important information from Tom. He remembered:

> Well, the way the pattern was, she would tell me that everything was going along fine and we would have these casual conversations about whatever was going on in a superficial kind of way and she would call up and say she was arrested for something or that she had taken the car out and not come back for two days or that she got suspended from schoool for smoking dope...and there were all kinds of things going on and I liked her and I'm sure she liked me and so we had a nice relationship but then my feelings would be hurt and I would feel crushed every time I would realize that there were all kinds of things going on in her life that she wouldn't tell me about and I'd really feel disappointed that she had these things going on.

This pattern apparently continued for the duration. Tom at no time experienced himself as making

any inroads with her or with family members.

In D8, Ken presented himself as being frustrated in his work with Ellen. For two years he had been seeing her for regular therapy sessions and at the time of his participation in this study, Ken was still working with her. He was particularly frustrated about Ellen's lack of change. Ken recalled thinking to himself: "How dare she not do this and not change her life after all I've done for her?" Sandra in D7 remembered being frustrated with Bill and Teresa. This stemmed from their insistence on talking about their problems with their two-year-old son and an avoidance of talking about their marital relationship. In response to my statement in the elaboration that part of her experiencing of difficulty was a sense that Bill and Teresa were focusing on the wrong issues, Sandra stated:

> Exactly, I mean, the presenting issue was really the child and after ten minutes with them I realized that really the presenting issue was their marital relationship and it was interesting once I verbalized that they weren't interested in looking at that at all. They really wanted to...they kept returning to the child and....
>
> I: How did that affect you?
>
> Sandra: It was frustrating in trying to bring them back to the focus of the relationship, which obviously they didn't want to look at, at the marital relationship. So, of course I kept thinking that in subsequent sessions that hopefully we can certainly focus on the

> marital relationship. Today they just seemed to really want to ventilate about their feelings about this child.

Somewhat different was the source of Peter's frustration in Description 3. As noted in section 4.1.2., it was not Kathy's inconsistent behaving that Peter found frustrating. It was the way other professionals inside and outside the hospital responded to Kathy which he found most frustrating and his inability to convey to them his confidence in Kathy's progress.

### 4.2.2 Experiencing Particularly Strong Emotions

All participants recalled experiencing particularly strong emotions in the presented situations. Anger, irritation and annoyance predominated over other emotions. In D4, Tom was angry with all members of family T. He recalled:

> I remember feeling angry with all of them, feeling angry with the father who was a very wicked, sanctimonious, judgmental kind of guy who was judging his wife and kids and I felt angry with the mother who wouldn't defend the kids with him and she just didn't have the personal wherewithal to be able to confront him on his behaviour so I felt bad that he was hurting her and the kids, who were caught up in this whole trap. They used to do all sorts of outrageous things to fuck up their lives and piss off their parents and they would make me angry too so I just, I felt angry with all of them.

In D7, Sandra experienced a tremendous amount of

anger toward Bill and Teresa for desiring to give up their two-and-a-half-year-old child for adoption. Note her very strong feeling about the issue in the following passage:

> As a parent myself, my initial reaction was one of horror and disgust. How can anyone want to give away their child, especially after being with the child almost two years? My own maternal feelings of nurturing and child-rearing were obviously struck. With Teresa's comments regarding never loving her child or wanting to have him, I found myself angry and wanting to make a punishing comment, such as, how unfair for you to wait until the child is almost two to make this decision, or why didn't you give the child up right away?

In that session, Sandra recalled that her anger and frustration with Bill and Teresa was so strong that she wished they would leave the office:

> My feelings of frustration were building at this point and I wish they would get out of my office. I feel as if they made a decision not to communicate or consider change. It's like they have both aligned against the therapeutic process and the therapist. Why are you here, Bill and Teresa?

In D1, Debbie became exasperated with Janet's ongoing acting-out behaviour and lying. Debbie found working with Janet trying under these circumstances:

> I was angry at her. I thought she was acting more like a three-year-old in a 27-year-old body. I got annoyed. It was a coward's way out.... Well, just sort of like you become cynical. I really felt she got what she deserved.... You feel with you she should always be truthful. She would rearrange all the events so that she wouldn't look at all as if she was guilty and then if I am going to advocate for her then I can't because I am basically going to advocate for someone who is

untruthful so there goes that down the drain.

In D5, Saul remembered the anger and indignation he experienced when Monica attacked him vehemently:

> I guess at its worst, it was like, well there is a feeling of defensivelessness that goes along with it and here my job is to help this person and I have to take a wrath of shit in order to be able to do it so there were times when, you know, when I was thinking to myself basically, I don't need this shit. I mean, who are you to tell me that I'm ineffective interpersonally when her life is a disaster. So, at its worst, it would be like, yeah, could you at least spare the patronizing part of things here. It really bugged me.

Along with the anger and indignation were feelings of "depression" and "sadness" that he was unable to make a "person-to-person connection" with Monica. At times he recalled feeling "worthless" for "even though I believed that I knew quite a bit about her condition that I did not know enough to present what I knew to her in a way that was helpful to her, basically feeling limited in the extent of my knowledge".

### 4.2.3 Experiencing Uncertainty in Their Actions

Typifying all therapist experiences in this investigation was a sense of uncertainty about how to proceed in the various situations. Larry remembered thinking about different orientations in his efforts to conceptualize Norma's difficulties and provide an effective intervention:

> I tried to conceptualize what was going on with this particular problem.... There was some thought that there might have been some separation anxiety here because at one point when dad sent mom some flowers this girl was wondering if dad was having an affair and another time she asked one of her friends if this friend's parents might possibly be getting a divorce. It also turns out that the parents of very good friends of hers got divorced.... It was somewhat obvious to me that the kids were running the parents in this family and that there was an inversion of the power structure with the power being in the sibling subsystem rather than in the parental executive system so this family could have very well been worked with a la Cloe Madanes and Jay Haley correcting the power hierarchy in the family.... I should mention that I did assess the possibility of her use of drugs and alcohol and found this to all be negative to the best of what we could find out talking to the parents and to the school people. I attempted to determine the antecedents to her school avoidance in terms of perhaps other kids who were giving her a hard time and intimidating her and I couldn't turn anything up here.... When you think of certain situations, for example, using brief problem-focused therapy, you've got to have a client that has a problem and that can be defined and that they are willing to work on and the folks who follow that particular school would say well, the child wasn't really particularly motivated. It was the parents who really had the problem. What I probably should have done was work with the parents and not seen the child because it was really the parents who had the problems and acknowledged they had the problem....

In D3, Peter pushed forward in his efforts to move Kathy toward discharge in spite of uncertainties about the extent to which her labile behaviour was stabilizing. In D5, Saul was very unsure about the effectiveness of his interventions for Monica. Feeling

as if he were under a microscope, Saul repeatedly reflected upon the efficacy of his actions:

> It's like that range of behaviour that I have as a therapist, it is under scrutiny and under question and unsure becomes much larger with a person like this so that the okay feeling, the times that I felt okay, the percentage of that time was much less. I would still have the kinds of feelings when I was under her scrutiny or under her attack, but like I said, it was much more effort expounded in order to feel as though my head and my feelings were congruent, I guess. There were other times when I was working hard to react therapeutically but what I would say or do I wasn't sure of the rightness of it and so there would be an unsure feeling, questioning myself and with this client constantly remindng me of my deficiencies, those interventions and those ways of responding to her which I might have normally felt okay about became questionable too.

Frequently, Saul felt double-bound, wanting to maintain the very behaviours Monica was critical of.

Somewhat different was Bob's experience of uncertainty in his work with Paula in D6. Paula had a long psychiatric history, including suicide gestures and threatening behaviour toward her children and stepchildren. After a number of sessions, Paula objected to having a male therapist. Bob was unsure how to respond to her request:

> It was one of those kinds of things though that I would really want to be sensitive to and say, well, that is a reasonable request. Let's see what we can do about it. But in reality, I had some real question about the fact that initially she seemed to have wanted to establish some relationship and then came up with this thing, made me much more questioning of it. I just was uncertain as to how to approach that issue. Maybe

> it was me, more uncertain than...but she often did that sort of thing.

Bob was uncertain about whether to support Child Protective Service's attempt to place the children outside the home. Although perceiving her as having negative influences and as being an incompetent parent, part of him felt that he could not take a strong position on this issue because he was her therapist. He remembered the confusion he experienced:

> I felt that they really should be placed and that the other agency, the Child Protective agency, was very reluctant to do that and I felt that I was sort of in the middle there, that I saw her need but because of me being her therapist, it was a little difficult for me to say as strongly as I wanted.

Compounding his sense of uncertainty was his not having a clear plan for working with Paula. He continued:

> ...I didn't have a clear plan during most of that period and that was part of my discomfort. Part of not having a clear plan, though, was that I kept feeling I ought to be acting some way in her best interest. I ought to be on her side and I kept not wanting to be on the side of a person quite like her.

Bob entered a co-therapy relationship with a therapist from an agency who had already met with Paula and her family on a number of occasions. Bob felt like a junior partner in the sessions and dependent on the therapist for leadership. This situation contributed

to Bob's feelings of uneasiness which peaked when he presented the case to the treatment team in his agency:

> Well, the team was very divided and although I would make the recommendations, I felt that it was somehow...well, the woman was obviously in need of something, a very pitiful woman in a way, and I thought that the therapy was an appropriate thing for her to need and the team was very divided about that so I ended up for a portion of this time recommending to the team that we not terminate her even though my sneaking suspicion was increasingly that perhaps we ought to do so. So the division of the team, with me tending to side with the side that I wasn't apparently siding with.

4.2.4 Not Being Effective

One of the central meanings specifying their experiences was a sense of having minimal impact upon the client or family. In D1, Debbie recalled that "the relationship seemed to make little difference to Janet's decisions about behaviour". In D4, Tom felt that he was ineffective in his work with family T in the year he worked with them:

> ...I liked both of the kids but I experienced them as being difficult because I never felt like I had any real impact on them. They never really let me into what was going on with them. They never really told me what was happening and they didn't really change much during the time I was with them. There was a sense of frustration for that in me...because usually I feel that I am able to establish the kind of rapport where people will trust me and this was a difficult case because I didn't feel it happened with these kids. They didn't have any people in their lives who they could really trust and they never reallly trusted me either. Well, going back and looking at the experiences that I had, the emotional responses

> that I had, finding what difficulty was for me in this case because I think this was the most difficult family I ever workd with; difficult because they had the potential to change but I wasn't able to assist them in realizing their potential.

In D2, Larry came to view himself and other professionals as being defeated by Norma. In his words: "She defeated me, she defeated to some extent the person who referred her to me, who was really not a psychotherapist. She certainly defeated the child psychiatrist."

Larry experienced that "this was the case that I probably did the least good".

In D10, Michael observed that Donald, a middle-aged man with a past drug and alcohol dependency and suffering from anxiety disorder, got sicker the more help he got. Initially Michael viewed Donald as one who would be a positive influence in the agency's group program and as one who would find employment and live independently upon completion of the program. Eventually he was experienced as being manipulative of the system. Mike described how Donald shifted from problem to problem while in the program.

> ...He had to present himself as sick. He came into the program somewhat assertive, healthy. He had the drug problem so as soon as we eliminated the drug problem, the dependence problem came and then the anxiety and the back spasms and all of that and then when the anxiety would lift, the depression would come and then when the depression

> wasn't there, the anxiety was there. It was just like a ping pong ball.

4.2.5. Struggle and Distancing

In many of the presentations one gets a sense of struggle occurring among therapists and clients. In D2, Larry continually struggled to persuade Norma to be cooperative in therapy sessions and to persuade her parents to go along with his suggestions for how to deal with her. He described their difficulties in following his behavioural interventions:

> If she didn't go to school, then they withdrew privileges but what happened was that dad couldn't deal with the fact that it seemed like his daughter was out-manipulating him. It was hard for them. They are people who are very much used to being in control. He has his own business and he runs it and he pretty much runs the house. He was the guy who couldn't deal so much with this.... Her parents, her mother, fell into a very helpless position where she would more or less cry and get upset. Mom was a little bit more agreeable but daughter would reduce mom to a total crying mess of jelly.... I gave her some tasks to do and she would not do them.... There were occasions when this child refused to come to my office for therapy....The child was very demanding.... She was constantly testing me in therapy to see if I was going to get angry at her and reject her like everyone close to her had....

In D4, Tom experienced his work with family T in a tumultuous fashion. Family members were well entrenched in their positions and fought Tom's efforts to influence them. He struggled with Connie to open up

to him, which she never did. He struggled with Mr. T, at times blowing up at him for "his unwillingness to change".

In D5, Saul outlined the struggle he continually experienced with Monica for control over the agenda and focus of therapy. He recalled:

> I felt as though I was under constant scrutiny, which for one thing was different from clinical situations in which people for the most part accept the therapeutic contract, understanding that why we are there is to look at his or her behaviour. In this situation the client was actively involved in redirecting the focus so that I needed to constantly respond to this redirected focus in a way that was therapeutic and not seeming defensive while at the same time feeling like I was on the defensive. ...A major effort in the therapy was to redirect the discussion to material concerning her rather than me.

In D10, the struggle between Mike and Donald is quite explicit. Each tactic Mike uses for helping Donald is countered by Donald. In the elaborations, Mike described how Donald repeatedly focused on negative aspects of his life even while others were trying to be encouraging:

> ...We enjoyed the strong points and stuff with Donald but then when the negative stuff just kept coming to us, it was very problematic. The hospitalization, "I want go to to the hospital. I want this. I want to be taken care of. I want to go to the nursing home." And here we are. We are building on strengths and all this man has seen is negative aspects. He is trying to portray negative aspects to everybody and it is not working. The group is telling him "Donald, you are fine. You are much better off than I am. Your anxiety doesn't appear to be anything near to

> my difficulties." And he would tell them "No, no, you just don't understand." Nobody understands that Donald just wants to be taken care of.

Eventually a process of distancing emerged in each of the situations with the exception of Ken, who was still working with Ellen at the time of his presentation. In D1, Debbie initiated a process of distancing as a way of dealing with her own anger and frustration about Janet's lying and acting-out behaviour. In D3 and D4, the distancing was circumstantial. Peter took a position in a different facility and he could not finish his work with Kathy. In D4, family T moved away after Mr. T accepted a position in a different parish. In D6, Bill and Teresa drop out after three sessions. In D10, Donald was referred to a different program for aftercare.

### 4.2.6. Experiencing the Situations as an Extremity

One of the common characteristics of the participants' experiences was a recognition that these experiences were generally nontypical of what they normally experience in doing therapy. Note the following comments from a number of participants:

> ...I experienced the greatest variety of difficulties I can recall of all the therapeutic situations I remember (Bob in D6).

> I think that this case may be revealing in that it is an extreme. I've never felt this annoyed with

> any other patients. Usually there is something that I find I can like about people. I found very little that I could like about this group as a family (Tom in D4).
>
> She basically was, I would say, the most difficult kid to work with, not that I hadn't had problems that sounded like hers, but the kids were sometimes a bit more cooperative and I really was feeling very frustrated with that (Larry in D2).
>
> Well [this exercise] is a reminder of uncomfortable feelings, a reminder of a situation that I was in and in which I felt ineffective and it forced me to look at aspects of myself and things that I've done that I would just as soon forget. That part of it was uncomfortable (Saul in D5).

## 4.3 Specific Themes

Specific themes identified common to two or more participants were: (1) reacting to client moment-to-moment behaviour, (2) being stimulated and challenged, (3) being judgmental, (4) unnaturalness of remaining in the situation, (5) being manipulated, (6) violation of therapist space, (7) awareness of larger system contributions, (8) bodily involvement, and (9) in touch with positive features of the client. An elaboration of each theme immediately follows.

### 4.3.1 Reacting to Client Moment-to-Moment Behaviour

A number of the participants became stuck to immediate manifestations of client behaviour in the situation. Unable to focus beyond the immediate

behaviour, their sense of frustration and helplessness seemed to emerge earlier in therapy. As well, they tended to manifest particularly strong emotional reactions in the situation and focus on the infuriating or frustrating aspects of the client, almost exclusively. Tom's experiences with family T is an excellent example. Tom became captured by the world of intense emotion demonstrated by family members in their reciprocal relationships. Note the following opening to his example and his elaboration in the follow-up interview:

Tom: (Starts to read) This is a family that I worked with that was difficult in every sense. I've decided that this was a difficult family to work with because I felt uncomfortable during the sessions and because I felt as though I made very little impact on the family.

I: Let me stop you here. What were the different ways you experienced the discomfort during the sessions?

Tom: Well, I remember feeling angry with all of them; feeling angry with the father who was a very wicked, sanctimonious, judgmental kind of guy who was judging his wife and kids and I felt angry with the mother who wouldn't stand up to him, wouldn't take a stand on things, wouldn't defend the kids with him and she just didn't have the personal wherewithal to be able to confront him on his behaviour so I felt bad that he was hurting her and the kids who were caught in this whole trap. They used to do all sorts of outrageous things to fuck up their lives and piss off their parents and they would piss me off too, so I just...I felt angry with all of them.

In another section of the protocol, Tom described

how he intermittently "lost it" and "blew up" at the father, "really lambasting him" in an angry way for his unwillingness to change, his unwillingness to recognize attempts that the kids made to make things go more smoothly in the family. He also experienced a sense of frustration and disappointment in the behaviour of the daughter during individual sessions for not being forthright about instances when she got into trouble.

Debbie rapidly moved from a position of believing that she could meet Janet's desire for help to a position where Debbie attended almost exclusively to Janet's negative actions and the emergence of a belief that Janet lacked a "personal core" for changing her behaviour. She viewed Janet as being "stuck in a groove which was comfortable and which she had no motivation to change". Debbie drew a distinction between Janet's paranoia and fearfulness, which Debbie believed were manifestations of her mental illness and her acting-out and lying routine which Debbie contended was a function of her "personal code of ethics" and for which "she should really be treated more as somebody who was breaking the law than as a psychiatric client".

### 4.3.2 Being Stimulated and Challenged

For some therapists, a characteristic of their

experience of particular difficulty included a sense of being stimulated and being challenged. Although Peter in D2 experienced frustration and anger in his work with Kathy, he also experienced his work as stimulating and challenging. He recalled:

> I must admit that there was something that appealed to me about having a client like her and that nobody wanted to go near her therapeutically. They literally did not want to have anything to do with her. I think that kind of a challenge I enjoy. I think it is a matter of being a person of last resort and also provides me with the opportunity of really working by instinct using a lot of intuition.

In describing the experience, Peter used terms such as being "challenged," "appealing," "enjoyable," opportunity for working by "instinct" and a "chance to work intuitively". In being challenged, Peter actively searched for a way to effectively work with Kathy. He came across information meaningful to him at a workshop he attended through a chance meeting with a colleague who specialized in working with borderlines. Her ideas were compatible with Peter's ideas about therapy.

Larry also experienced the situation with Norma as a challenge; however, in a different sense than Peter. The challenge seemed to be pragmatic. Being in a private practice situation, Larry noted that he had a good reputation. He was aware of being paid for his services and that Mr. and Mrs. R expected results from

his work with Norma. These factors probably inspired Larry to find an effective way of working with Norma and to prevent him from succumbing to temptation to react to Norma's "obnoxious and rotten behaviours".

4.3.3 Being Judgmental

Many of the therapists observed themselves as being judgmental of their clients' behaviours and attitudes. Sandra's feelings about Bill and Teresa's desire to give up their baby (see p. 111), Debbie's attitude towards Janet's desire to have a tubal ligation and Bob's view about Paula's parental abilities are elucidating examples of therapist value judgments.

Sandra noted how it was "easy to make value judgments" when experiencing difficulty but being the therapist, one could not express those judgments.

Debbie viewed her own value judgments as being valuable for "it brought to the surface my own negative feelings about someone who has that way of operating". Through her value judgments, Debbie was able to come in contact with her views of Janet's behaviour as bordering on the criminal and to draw a distinction between those parts of her behaviour and aspects which were related to her mental illness. Bob remembered

that he had developed an "intense dislike of Paula despite my ethical belief that I was to be allied with her". In response to my question about what kinds of things he said to himself about Paula, Bob remembered:

> Feeling that I wish the family would break up, I mean, what right had she to expect that anyone would stick with her through this kind of really frivolous, pretend suicide gestures.... I was appalled at the prospect of her continuing to act as negative influence and incompetent parent to her two children and yet her own interest was to remain in that role.

4.3.4 Unnaturalness of Remaining in the Situation

Already demonstrated were that many of the therpists experienced strong emotions and judgments about their clients. What many attempted to do was to suppress their intuitive responses. Tom attempted to suppress his intense dislike and anger for Mr. T. Bob experienced what he termed conflict between an "ethical belief" that he was to be allied with Paula and his intense dislike of her. Sandra was very clear that her responses to Bill and Teresa were dictated by her being in the "therapist role". In her response to my probe that intuitively there were many other things she would have liked to have said, Sandra noted:

> Well I think that me as...if you take the therapist out of the therapist role, yes, that would be something that one would be more inclined to say but in a therapist role certainly it is not something you come out with....

Debbie pointed out that in any other situation she would not have tolerated Janet's behaviour. Being in the therapist role the relationship had to continue no matter how unnatural it felt. In her words:

> Well, I think the fact that she is a client, you have that responsibility to keep on having a relationship to somebody whom you may not like after a while or you may disapprove of things whereas if it was just a regular person, you probably wouldn't have a lot to do with them. The fact that they are a client, you have to keep on this relationship.

Bob also shares this sentiment with regard to Paula, stating, "I think this might be one of the people I would least be likely to meet on the street and form some relationship with".

### 4.3.5 Being Manipulated

One of the characteristics of the experience of particular difficulty was a sense that one was being manipulated and controlled by the client. This was particularly true for those who presented situations involving chronic patients with psychiatric histories (Debbie, Arnie, Michael and Ken). Ken, in D4, described the pattern he experienced in his work with Ellen:

> ...there is a feeling that with this particular client that the game is to keep the problems coming so that you don't get to any solutions and it's like, boy, have I got one for you now, and by God, we will never get through this one.

Ken's experience appears to be similar to Michael's experience with Donald who continuously raised new problems and tried to manipulate Michael and others to do things for him. In his words:

> Yeah, if I said white, he had to say black. Anything I threw back for him to do, there were always twenty million reasons why he couldn't do it. It got to the point where he wanted me to do everything for him, total care. If he could have found someone who would just do everything under the sun for him, wash and bathe him, feed him, spoon-feed him, wash his behind if he needed it. That's what he wanted....

Debbie's and Arnie's experience of being manipulated stem from their clients presenting well and showing interest during sessions but never following up between sessions. Arnie described Jack's manifestations of manipulation in the following manner:

> My problem with Jack is this: He outwardly confides in me about personal matters and claims that I am the only person he can trust; however, I have observed and sensed in my own gut that he is not altogether truthful on this issue. When I am out of sight of Jack I believe that I am out of his mind along with what we have discussed concerning his problems.... My uneasy feelings and uncomfortable sensing of resistance centres around his not really listening or paying attention to what we talk about. He says something in our therapy session and then goes right out afterward and does the opposite. He appears to be using me as a sounding board and that's all. He does not follow through after our conversations and takes no considerations from our discussions and planning. I have a negative sensing or growing gut feeling that he is merely manipulating our relationship also. I take this as resistance....

Debbie often experienced Janet as attempting to manipulate her to support her during her conflicts with staff members in the residences. Sometimes Debbie would temporarily be influenced by Janet's in-session demeanour and think she could be helped but subsequent information about Janet's behaviour between sessions would dissolve any hope Debbie had that Janet would or could change.

4.3.6 Violation of Therapist Space

An important aspect of Larry's experiencing of difficulty went beyond Norma's uncooperativeness and into a realm where Larry experienced himself and his property as being violated or constantly under the threat of being intruded upon by Norma. He specified three examples where Norma violated property belonging to him, including his files, his attache case and his bookcase. These incidents and others led him to perceive her as the "rottenest and most obnoxious kid" he ever worked with.

A potential seemed to constantly be present for Norma to manifest destructive behaviour so that Larry was always on his guard:

> Sometimes I had to be careful because if you would leave her in the waiting room she would just pound on the door, make it so that you couldn't talk or she would go out and lock herself in the car....

> If you left her in the waiting room, you didn't know what she would do. She was liable to wad towels down your sink drain and then you would have to get a plumber. I mean, you didn't trust to leave her anywhere.

Saul experienced his psychological space as being intruded upon by Monica. He noted how she violated expectations in therapy that the focus be on the client's world and not the therapist's. Monica repeatedly attacked Saul, stating that he was "flawed interpersonally," "had difficulty being close to people," "ineffective person". Saul remembered:

> Well, I felt as though I was under constant scrutiny which, for one thing, was different from clinical situations in which people for the most part accept the therapeutic contract understanding that why we are there is to look at his or her behaviour. In this situation, the client was actively involved in redirecting the focus so that I needed to constantly respond to this redirected focus in a way that was therapeutic and not seeming defensive while at the same time feeling like I was on the defensive.

His efforts bore no fruits and Saul was left with many ambiguous feelings and a deep sense of uncertainty about his interventions.

### 4.3.7 Awareness of Larger System Contributions

In Peter's and Bob's and my own presentation, there was an experiencing of elements within one's agency and outside agencies that contributed to an experience of difficulty. Peter described how other

doctors in his facility and professionals in other agencies contributed to his sense of frustration and annoyance in working with Kathy:

> Well, we had a series of doctors who were psychiatric residents. Depending upon their personality, they had different reactions to her. Those people that needed to be liked by the patients hated her because there was no way.... She sucked you in by saying, oh, you're so nice! That staff member that needed that, as soon as she turned on the staff member couldn't take it. Really began to hate. I had done a lot of work with her and we both dealt with the frustration of the delays bureaucratically in getting someone discharged from the hospital, setting up the interviews, setting up the appointments, going to see...a thousand and one things that needed to be done! It wasn't easy and it was very frustrating at this end where I was always looking at her baseline and trying to ignore her shit...and I couldn't really convey that to people in a way that would give them a sense of confidence. They were only interested in, give me a reason to reject you, go on! And there's a lot of shit like that and I really resented it and I let people know.

Bob remembered the difficulties he experienced when the referring agency did not terminate with Paula as scheduled. He described the confusion and discomfort of being a co-therapist with someone who was supposed to terminate with her and didn't for a long period of time:

> ...I met with the therapist and with the family a number of times and since he was the person who had been doing the therapy all along, it was he who took the primary role, the leadership role in the family sessions and I kept feeling that I was not having a clear enough idea of any understanding. We did not have a sufficient understanding between the two of us as to what we

> wanted to do. I ended up depending on him to have some understanding there, some leadership role, which also then made me appear, or so I felt, very much a junior person, very much less authority.... If I weren't at those meetings, then he was continuing to be the primary therapeutic relationship. If I were at them, I came off as being sort of compared with this other therapist.

Also contributing to Bob's sense of uncertainty was the division within his agency's treatment plan for Paula and over the question of whether Paula should be accepted for services by the agency.

In my contribution, I experienced the school psychologist who had referred Fay to our service as a major impediment. I wrote:

> As it turned out, Fay was already involved with Ted and had been for a number of months. He saw her on a daily basis in his office, including frequent occasions when she should have been in class. He accepted phone calls from her at home seven days a week and all hours of the evening. When Fay had gone to Disney World with her family, she called him collect to tell him how depressed she was and he accepted her call. He appeared to collude with Fay about keeping information about her self-destructive thoughts and actions from her parents as well as in not referring her to Mental Health at an earlier occasion. Immediately I recognized that Ted was part of the problem and would have to be considered and worked with in an active manner.

### 4.3.8 Bodily Involvement

In some of their descriptions, there is an awareness of one's physical self feeling different than

usual. Tom described his bodily feelings while attempting to cover up the anger he experienced in the sessions:

> ...my shoulders and I felt it in the pit of my stomach, yeah, just that kind of general tension, just a tightening all over with the anger and since I usually held it in, I was holding back but I could feel the tension of holding it back.

By the end of a session with family T, Tom was often "exhausted," "drained" and in need of "a breather" before going on to the next session.

Mirroring the uncertainty and lack of spontaneity in his sessions with Monica, Saul remembered his body as being "tense and stiff" and that he tended to be "slow and mechanical". After sessions he also felt drained and exhausted. Being the last sesson of the day, he would often go home and not feel like doing anything the rest of the evening.

### 4.3.9 In Touch With Positive Features of Their Clients

In spite of intense emotions experienced towards their clients, a number of therapists still achieved contact with aspects of their clients they enjoyed. Debbie admitted that Janet was able to be "a nicer person at some times" and she noted "her intelligence and her humour". Saul described aspects of Monica he

liked:

> It was a caring and thoughtful part of her. She was bright and had a good sense of humour. And now that I'm talking about it, that's perhaps one of the reasons why working with her had become so distressing because I did like her and yet never made the kind of connection with her I would have liked to have made.

Mike perceived Donald as being very capable and independent and this served as an inspiration for the time and effort Mike invested in his work with Donald.

4.3.10 No Change Interpreted as Client's Inability to Change

Many of the therapists attributed lack of progress to characteristics of the client or family. Debbie claimed that Janet could not change because she lacked the "personal core" to do so and because she had no "conscience". She pointed out Janet "continued to use mechanisms of projection and denial in her dealings with others and often seemed to have no conscience". Tom claimed that members in family T did not possess the "emotional wherewithal to be able to do anything much different". Saul explained Monica's lack of change in the following manner:

> ...ongoing struggle to decide whether she was bad and defective or the people around her were bad and defective. This sense of commotion in most of her interactions with others and certainly with me was an effort to find the flaws in the other person in order to relieve her of thinking of

> anything that might be wrong in the relationship might be due to her. I believe that I only recognized when it was too late that even when I was being appropriately empathic and our interactions were as good as they could be that she was in such distress and such a need to put that distress outside herself that I could not be seen as the helpful person that I would have liked to be seen as.

An exception was Ken's explication. He examined his own behaviour and noted how his combative stance, personal family issues, and tremendous investment may have contributed to her lack of progress:

> In terms of my own reactions to this, one that I'm kind of concerned about, I think at times I have seen myself as being combative with Ellen for the sake of being combative and yes, of course, trying to break through for hope, for therapeutic gains but I also see just the desire to win or to prevail as being part of my motivation and at times I've seen myself going after points with her that wasn't really for the client's best interest. It was for my needs to prevail.

Ken reported that many of his sessions went over the time and often he took the case home with him. He stated that it was "important for a therapist to have some self-correcting mechanisms where you can, using supervision or using your own when you are in there alone, something that a buzzer goes off and tells you, hey, wait a minute, you're going too far".

A discussion of the findings ensues in the following chapter.

# 5. INTERPRETATION AND DISCUSSION

## 5.1 Introduction

In this section, the descriptions from the previous chapter will be interpreted and discussed in light of the research questions, as stated in Section 1.5.

The questions were: (1) What does it mean to experience particular difficulty in therapy? (2) How can one understand the place of the concept of resistance in light of this investigation? (3) How does the study contribute to the literature concerned with meaning in therapy?

## 5.2 Interpretative Description of the Experience

Beyond providing a context for understanding participants' worlds revealed through the texts, how the presentations are organized provides the reader with a way of viewing my own world-as-investigator and includes the biases specifying which horizons of the experiences I attended to. Varela (1976), in his ideas about how biological and human systems are experienced by observers contended that the subjective origin of knowledge is a reflection of the ontogeny of the knower and that knowledge "as a descriptive conduct is

relative to a cognitive domain of the knower" (p. 48). My own past experiences as a psychotherapist, socio-historical factors such as the graduate school I attended, the mentors I was attracted to and the theories I adopted all played a part in how I structured the study, and in determining what characteristics of participants' experiences were meaningful to me.

## 5.3 Meanings of Experiencing Particular Difficulty in Therapy

A major characteristic of the experiences of difficulty was the strong emotional reactions participants recalled having in the situations. Therapists experienced themselves as being frustrated in their attempts to be helpful. Frequently feelings of anger, irritation and helplessness were expressed as participants experienced themselves as being ineffective. Tom put tremendous effort in attempting to control the anger he was feeling toward Mr. T. Bob hoped that Paula's family would break up and that she would not continue to be the caretaker of the children. Sandra was extremely angry with Bill and Teresa for their wish to give up their two-year-old child.

Psychotherapists enter therapy situations with an expectation that they can have an effect on their clients and that something better, however that is defined, will be gained by the client. There is an assumption that the client or family will somehow benefit by being in contact with one as a therapist.

In each of these situations the participants began to realize that they were having very little impact on their clients and most likely would not experience themselves as successful. The realization was often not present from the outset and the shift from an expectation of success to an expectation of impasse was often gradual. Debbie initially thought a relationship had developed with Janet which Janet would use therapeutically. Saul initially believed he could help Monica in that he knew a lot about her problems and he believed he could find a way to work with her. Ken constantly thought that Ellen would change as a result of his interventions.

The participants became aware that these situations were not typical of their general experiences. Usual therapy techniques were not being effective. It was not business as usual. Tom could not influence Connie to be honest about the problems she got into at school. Sandra was unable to get Bill

and Teresa to focus on marriage issues. Arnie could not get Jack to carry out his suggestions between sessions. In identifying the situations as problematic with little hope for successful outcomes, participants generally became more frustrated. Increasingly they were perceived in negative ways. Debbie came to view Janet's behaviour as bordering on the criminal. Mike experienced Donald as a "con man" who knew how to manipulate public agencies. Tom experienced Mr. T as "sanctimonious, rigid, unforgiving and very cold with his kids". Sandra experienced Bill as being "blase" and "aloof". Some participants seemed to lose their usual perspective for doing therapy and reacted to moment-to-moment behaviours of the client. Others, such as Larry and Peter, maintained their perspective and they continued to search for ways to be effective. Although experiencing frustration and anger in their situations, Larry and Peter were different from many of the other participants in that they didn't allow those feelings to overwhelm them. This will further be examined in Section 5.3.1.

As participants continued to feel annoyed and irritated, some of them remembered feeling judgmental about client behaviours. Others experienced themselves as being manipulated or having their own

personal space violated. Some began to experience their bodies differently. Shoulder pains, tension headaches, and general exhaustion were some of the body reactions recalled in the situations. Physical discomfort was particularly exacerbated when therapists struggled to keep their negative feelings under control. Many therapists admitted that they would not have maintained a relationship with the client or family if it was not for this being a therapist-client relationship. Some were very cognizant of the dilemma between their view that as a therapist they should want to help the client and their antagonistic feelings toward certain client behaviours.

There are many non-typical components in the situations the therapists presented. As Tom pointed out, his experiences with family T stood out in that it was an extreme case. It would appear that in choosing their cases, participants contrasted everyday situations where therapy proceeded as expected, to other situations where something problematic was experienced.

Being angry and frustrated in a situation became salient when in similar situations one was generally calm and proceeded as usual. Experiencing headaches and shoulder tension stood out when in other situations

one did not typically experience these feelings. Wanting not to be in that situation stood out in contrast to situations where therapists want to work with their client and believe they could be helpful.

In his study of the phenomenon of being frustrated in situations such as trying to piece together a different puzzle or waiting for someone intimate to come and visit, Burbridge (1977) also viewed the presented experiences as being meaningful in contrast to more typical situations. He wrote:

> ...For the most part we are not critically aware of,the rational structures of our lives, or of our body. We perceive, accept and use them. Objects are spread out and separated in space before us. We move easily from here to there. We may start something then give it up and do something else. Time slides along evenly; moments pass. One moment seems to follow another in sequence. The world is more or less clearly apprehended, if we need to focus our attention and concentrate, we do it. We act upon objects. That is the way things are; these constituents are normal. (p. 189).

In being frustrated, one lives a transformed situation in which many of the above meanings don't apply. A world-originating object may be experienced in some kind of conflictual manner whether it be "automobile jacks [that] refuse to work, puzzles [that] corner him" (ibid.) or clients who refuse to cooperate or change. The implications, according to Burbridge, cannot be avoided.

> The frustrated person slips beneath the traditional-reasonable (and in this case ineffective) modes of experiaction. He is well on the way toward becoming fused-with/embedded-in/captured-by the physiognomy of his situation.

In this situation, one is at a loss of what to do. The person can no longer count on his body'ssmooth functioning. "One's thoughts may be too-clear and too-persistent" or "too-unclear and too-muddled." One may experience a "true subjectivity of objects" that is no "longer the center of his world" but one "to which things passively happen" (p. 190-191).

Burbridge's account appears to be particularly relevant to this investigation. Every therapy situation is unique in that clients and families bring to the situation experiences, attitudes, and beliefs with regard to the manifested problems distinctly theirs. Therapists bring to the situation experiences, attitudes and beliefs regarding the nature of human problems and how to do therapy distinctly theirs. In the process of therapy, each provides the other with information about his or her view of the problems and steps toward solution.

In my view of taken-for-granted therapy situations, at least some understanding and agreement is achieved as to the nature of the problem, how to proceed in therapy and what constitutes progress. A

cooperative relationship emerges. There is a sense that therapist and client are working together toward a common goal. There is no reason for the therapist to question his or her conceptualizations. In those situations, doubt is often suspended as to the reality of one's therapy orientation.

In contrast, this study has demonstrated essences of the experiencing of particular difficulty which were very different from features of taken-for-granted situations. Most of the participants became aware that cooperative relationships were not emerging. Subsequently the situation took on frustrating qualities for them and in doing so a number of atypical characteristics became salient. Antagonistic feelings emerged toward clients. Participants became uncertain about the efficacy of their interventions. Some began to react immediately to client behaviour. Some experienced themselves in a struggle for control of the situation. Others felt they were being manipulated or violated. Still others became aware of uncomfortable bodily reactions.

Burbridge (1977) found in his study that in addition to experiencing objects as frustrating, participants often experienced themselves as a source of frustration. He suggested that participants often

felt stupid and embarrassed, which led to a wide range of feelings such as inadequacy, disgust and depression. They became involved with their own affective preoccupation which seemed to increase their sense of frustration.

With the exception of Ken, none of the participants in this study recalled being preoccupied with their own self-doubts. At times, Saul felt "worthless," "sad," "dependent" and "angry" at his inability to make a person-to-person contact with Monica. He struggled with his feelings. However, he never did view himself as the frustrating "object" in the situation. The source of frustration generally lay out there in manifestations of client behaviour. Their reflections did not include self-examination of themselves nor did they refer to how they could have acted differently.

Burbridge found in his study that participants were able to leave the frustrating experience through body or perceptual reflection. As a gradual experiential distance opened up between the person and individual, the subjects were able to regain a perspective on the situation and themselves and new possibilities for dealing with the situation were revealed for the person.

In this study, many participants reflected how it was very difficult for them to distance themselves from the situation because of their being in the role of therapist. Even in situations where the participant disliked the client, they believed it was inappropriate to end the association because of the context of the relationship. Therapists often remained, struggling to balance their negative feelings and their beliefs that they were supposed to be helpful.

Burbridge noted that one of the perspectives often regained in the distancing process was a shift from a feeling that one was unable to solve the problem to a perception that the problem was "unsolveable" (p. 193). This finding is relevant to this study as many of the therapists took a position that their clients' problems were unsolveable. Tom observed that family T did not have the emotional wherewithal to achieve meaningful change. Saul claimed that Monica's need to see herself as all good and the world as all bad made it impossible for her to have achieved anything in therapy. Debbie observed that Janet was a person without a conscience "and how do you work with that?" One exception was Ken, who viewed some of his own actions as contributing to the lack of progress in his work with Ellen. Often he experienced himself as being

combative with her. In response to my question about how he experienced that, he stated:

> Trying to out-argue and in that fashion feeling, hey, wait a minute! Once in a while catching myself, what am I doing here? Who am I doing this for? But I want to win this one, and that is really disturbing. I think this patient has benefited in therapy but it has been very tedious and compared to other members of the family, she is doing quite well, but while you are in there with her, it just seems you are getting nowhere.

Some of the things Ken recalled saying to himself were similar to the irrational beliefs Ellis (1985) explicated in his chapter on how therapists are their own worst enemies. For example, Ken remembered thinking to himself, "How dare she not do this and not change her life after all I have done for her? I've been so good to her. I've poured so much into this."

### 5.3.1 Influence of Context and Orientation on How One Acted and Reacted

Although most of the participants experienced strong emotions that seemed to paralyze their abilities to be effective, there were a number of exceptions. Peter and Larry continued to actively pursue therapeutic objectives although feeling frustrated and angry in their situations. These therapists remained free of immediate reactions to client behaviour. For

example, while Peter found Kathy's mood swings difficult to work with and while he occasionally became angry with her, he also experienced the project as stimulating and as a challenge. He used terms such as "appealing," "enjoyable," opportunity for working by "instinct" and a "chance to work intuitively". As seen in Peter's description from Chaper 4, he enjoyed working with Kathy and until the time he left the setting, he continued to work with her with clear therapeutic objectives in mind.

The question that needs to be asked is why Peter did not become trapped by Kathy's emotional lability when other therapists such as Debbie and Saul became hooked to their patients' behaviours? Kathy's attacks on Peter would appear to have been just as vicious as Monica's attacks on Saul. Yet Saul reacted in a strongly emotional manner while Peter, although at times extremely annoyed, always remained focused on his therapy objectives.

I think a partial answer lies in the orientation and influences that one brings to a therapy situation. Coming from a family therapy background, Peter was able to view Kathy's behaviour within a broader context that included the role of the hospital and its personnel in maintaining Kathy's behaviour. Although he did not

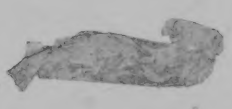
discuss her experience in a strictly systemic manner, he was able to remain relatively free from responding to Kathy's behaviours and instead he asked himself questions like "How do I work with her? What do I do now?" Peter used his resources to search for a way to work with her. His family therapy background allowed him to accept guidance from someone who suggested that he accept Kathy's behaviour as normal and not try to change it and who suggested that he work on getting Kathy discharged from the hospital.

The latter suggestion emerged from a view that the structure of the hospital fed on and helped perpetuate the behaviours of people with problems similar to Kathy's. Indeed, Peter exemplified in his description how psychiatric residents came to dislike Kathy and how staff from community residences seemed to do all that they could to ensure that Kathy would be rejected from their programs.

Therapists who come from a family therapy orientation are likely to bring with them into therapy an ability to accept and work with whatever problems and behaviours a client or family brings to a situation. This does not mean that they will never experience themselves as frustrated and angry in particular instances. Indeed, Peter, whose major

orientations included family therapy, was quite clear about his sense of frustration in working with Kathy on discharge and occasional feelings of anger regarding her behaviour. However, because of its basic assumption that behaviour occurs in a context of reciprocal relationships and that it is through an understanding of patterns of relationships that one understands the meaning of one's behaviour and how to act to change behaviour, one would expect family therapists to be less vulnerable to being captured by clients' problem behaviors in sessions. Indeed, system therapists often use a client's problem behaviour to bring about behavioural change. For example, a problem behaviour (e.g. adolescent acting-out) may be framed by a therapist as providing a solution for a different problem (e.g. keeping parents from fighting with each other by focusing on the adolescent). When offered in this form to the family, quite often a change results in the problem behaviour.

In contrast one would expect that adherents of orientations who viewed certain behaviours as being irrelevant or antitherapeutic would be more likely to become reactive to client problematic behaviours when experiencing frustration and anger. As an adherent of a psychodynamic orientation, Saul pointed out that



Monica's need to split between a good self and bad self made it impossible for him to have any effect on her. Debbie observed that Janet lacked the necessary intrapsychic structures to benefit from verbal therapy. In neither situation could the necessary relationship emerge critical for allowing transference issues to surface. Given these attitudes, nothing more could be done for these clients so one could more easily be drawn to becoming preoccupied with the client's miserable behaviour.

The importance of the work setting in determining how a therapist responds to his strong emotions is exemplified in Larry's presentation. Like Peter he experienced his work with Norma as challenging; however, in a different sense. The challenge aspect was pragmatic, related to the fact that this was a private practice situation. As Larry stated, he was getting paid by Norma's parents and they were expecting to see results. He also was proud of having a good reputation as a psychotherapist. These factors seemed to inspire Larry to try to find effective ways for working with Norma even though many of Norma's actions were provocative during the sessions. He clearly did not enjoy his sessions with Norma yet he never capitulated to reacting to her in-session behaviours.

Haley (1986) in his essay on "Therapy - A New Phenomena" also echoed this observation that work setting influenced how a therapist works. In exploring the practice of therapy in different contexts including private practice and mental health agencies, he concluded that "therapy must change its nature when it changes its contexts" (p. 150).

Of real importance would be to examine the implications of working with people who consider themselves failures in therapy, many of whom frequent mental health centres and outpatient clinics, and involuntary clients which are the bulk of the population in psychiatric hospitals.

### 5.3.2 Experiencing Uncertainty

From my perspective, experienced therapists in a therapy project typically appear to have a sense of direction and understanding of what to do in a particular situation. In their work psychotherapists bring to a situation a taken-for-granted expectation that orientations and methods which have worked in the past will be effective. In typical situations therapists feel okay about how their interventions affect the client or family.

It is only when a situation becomes problematic

that a therapist may question his manner of working in those circumstances. A number of the therapists including Larry, Peter, Tom, Saul and Bob experienced a sense of uncertainty about their interventions in the situations they presented. They each questioned the efficacy of their methods for those situations.

Schutz (1962) pointed out that as long as one's typical manner of understanding and doing was successful in an area of living, we trust those experiences and we have no reason to explore the issue further. He continued: "It needs a special motivation, such as the eruption of a shock experience not subsumable under the stock of knowledge at hand or inconsistent with it to make us revise our former beliefs" (p. 228).

In this study, none of the participants questioned the beliefs they held about therapy. If experiencing particular difficulty in therapy continued to be non-typical, one would expect the experiences would inspire a therapist to reflect on his or her orientation and perhaps look for alternate conceptualizations to guide one's work. At the same time it is not altogether clear that this would indeed be the case. Frequently, therapists hang on to their theories with a great deal of passion. Watzlawick (1983) elegantly spelled out

how therapists may be as much concerned with defending their own orientations from attack as trying to help clients:

> The question of what is abnormal and what is normal and how the former can be changed into the latter is complicated by the fact that psychiatric theories are held by their authors and subscribers with much greater fervor than, say, those of the physicist or the economist. Since they do not involve merely impersonal issues but the human being as such, they are almost always in the nature of religious beliefs and the basic belief may not, must not be wrong.... If this is so and if actions taken in accordance with the theory are unsuccessful, the fault must be sought in the applications of the theory but not in the theory itself. This means further that in a very real sense the point of therapy may be to save the theory, not the patients. And it finally means also within the framework of any theory certain deductions are consistent with its premises and others must be ruled out as inconsistent. (p. 213)

None of the participants reflected upon their theoretical orientations to examine whether the approach may have been inadequate for guiding their doing of therapy in these situations. As demonstrated, many of the therapists put the blame upon client qualities. Clearly one's theoretical and practical approach is laden with value and meaning. It could reflect the graduate school one attended and the mentors under whom one studied. One may have a tremendous investment in remaining connected to a certain system of knowing. To give up one's orientation or add new ones could be very trying.

Therapists may be able to tolerate a great deal of uncertainty in their work before being open to ideas stemming from other paradigms.

5.3.3 Not Having an Impact on Client or Family

Although mentioned earlier, the experience of having very little or no influence in the situations was so common it is worth examining on its own merit.

Traditionally, it has been accepted that inherent to one becoming a therapist lies a desire to help people in need. Anderson and Stewart (1983) stated "that most therapists have chosen their profession because they are invested in helping people" (p. 1-2). Tom, in explaining why he has had limited contact with chronic patients, noted, "I haven't been able to affect much change and the reason that I am in this business is so I can experience the changes that people have made. That is what I really get off on".

Recently the assumption of being helpful or influential or impactful as the purpose for why therapists become therapists has been challenged by the ideas of Humberto Maturana, a Chilean biologist. His ideas about living systems and the biology of language have stirred great interest among increasing numbers of therapists, and have served as a theoretical framework

for describing and validating what these therapists do. Prior to presenting his challenge, a short summary of Maturana's ideas from Efran and Lukens (1985) article are presented as a context for understanding his view of purpose.

5.3.3.1 Maturana's Theory of Structural Determinism

Briefly, Maturana's ideas and descriptions centre around the proposition that all living systems are structurally determined and organizationally closed to the outside world. That is to say, how an organism behaves and how it responds to the outside world are products of the structure and activity of its own nervous system.

One's action reflects the structure of oneself as an organizationally closed organism and not a response to an external world. As Efron and Lukens (1985) contested, "people do what they do because of how they are put together and they do it in connection with (but not on direct instruction from) the medium in which they exist, which includes other people" (p. 25).

In a process of what Maturana refers to as "structural coupling," people select from each other behaviours and ideas that fit together, therefore creating a shared meaning which enables a relationship

to be formed. When the fit becomes inadequate, the structural coupling disintegrates and a drifting apart occurs. An important notion is that living systems are seen as existing entirely within "a purposeless drift" in a medium (p. 24). As Efran and Lukens explained, in this drift, there are continual shifts in response to changes to both the external environment and to internal perturbation until a point of disintegration occurs which could happen at any time.

An important aspect of Maturana's work has been his description of human beings as observers and the role of language in this process. As observing systems, people "describe, distinguish and delineate in language. Language is the medium through which events exist, in which there are beginnings and ends, important and insignificant events. An event has no separate existence from our distinguishing it in language" (cited in Simon, 1985). Maturana argued that language and the observed areboth the "instrument as well as the problem" (p. 37). For while "it is only in language that we are observers" (ibid.), and one observes what one observes, the achievement of consensual reality is frequently confused with the notion of objective reality.

> Language created the illusion that we can look out and see a separate outside world. In fact, we

> never actually leave the domain of our activity and interaction. In this epistemology, there really is no independent object of study since there is nothing objective in parenthesis. Objectivity in parenthesis encourages a view of the world as being multi-verse as opposed to universe. (p. 25).

It is only in the domain of language that attributes and notions exist and with this I return to Maturana's challenge of the inherent notion that therapists have a purpose to their existence; that is, to help or have impact on clients. Efren and Lukens elaborated:

> ...a whole series of notions near and dear to therapists, such as `purpose,' `change agent,' `the function of symptoms,' etc. can be seen as observer attributions rather than accurate characterizations of system attributes. The attributions have currency only in the language domain in which they were constructed. (p. 27).

Later they continued:

> Terms like a purpose are part of an observer's attempts to give meaning to a past and a future within a `now'. They are partial descriptions of our activities. We tend to think and talk about our lives in terms of such stories. Life, in and of itself, is purposeless. (p. 27).

Given this model, the assumption that therapists desire to influence and to help bring about a change in their clients' situations can be viewed as questionable. Statements about altruistic values belong to the domain of observer attributions and are considered to be non-informative about the therapy

situation. According to this view, therapists do not have a passion for bringing about change but rather enter a relationship with clients in which a purposeless co-drifting continues until it disintegrates and each party goes its own way. Change may indeed occur for client or therapist but this is viewed as a chance outcome of the relationship. Therapists cannot directly instruct or direct clients to change but at best may select responses already part of a client's repertoire that results in a perceivable change.

Colapinto (1985) challenged Maturana's claim of purposelessness in the activity of therapists as well as life's activities in general. In his understanding of Maturana's notions, Colapinto argued that this theory could lead to a non-interventionist interpretation to therapy and larger social issues. He elaborated:

> If families can only be themselves anyway, we can stop trying to change them. If we do not try to influence other people's lives, we cannot fail or be held responsible for what happens to them. If they do not change, it was because they weren't supposed to, not because we did not know how to help them. We can also be more tolerant toward larger social circumstances and stop trying to affect them from our under-funded agencies.... (p. 30).

Given this possibility of interpretation,

Colapinto suggested an alternative way of viewing therapy consistent with Maturana's ideas. The view would include a conceptualization of a desire to change as being "intrinsically constitutive of a therapist". He elaborated:

> The passion to change others is - to use Maturana's terms - intrinsically constitutive of the therapist's part of his 'organization'. Philosophers and other observers were created to contemplate, but therapists only have a right to exist if they can contribute to transforming something bad into something better. 'Bad' may stand for 'enmeshment,' 'introjected object relations,' 'resistance' or 'a deflective conditional reflex,' but for therapists there is always an adversary to be conquered. If we lose our passion to change, we might as well disintegrate as therapists and become philosophers of biology like Maturana.

The differences between Maturana's views and Colapinto's views lie in the different contexts of observation from which each stems. Maturana's ideas emerged from a domain of observation of an outside observer. He participated in his observations through the ideas and conceptualizations he brought to the situation. Colapinto's challenge emerged from a domain of observation of a participant-observer who was part of the therapy process. Colapinto suggested that "passion for change" ought to be considered part of a therapist's organization and not as an observer attribution. In writing about his beliefs about

therapy, he was writing them from a domain of a participant observing his participation in the process. From that position, it was inconceivable that therapists do therapy without a passion for change.

Both views have the advantage of different perspectives and both visions are limited by the constraints of one's observational domain and the subjective self. They are both partial descriptions of what one observes and both are useful in providing information about the nature of therapy. In this study, participants described the meanings of particular difficulty from a domain of the participant observing his participation. As has been explicated, for practicing therapists, the feeling of experiencing oneself as being stymied was unacceptable.

5.3.4 Larger Systems Contributions

In Peter's, Bob's and my own examples, there was a clear experiencing of elements within one's own agency and outside agencies as contributing to our experiencing of difficulty in these therapy situations.

It may not be the client or family behaviour per se which is the impediment for solving the problems but rather one's own workplace or other involved systems. Their way of working may actually contribute to or

maintain the difficulties clients and/or therapists experience.

As a frame for understanding how larger systems may contribute to one's experiencing of difficulties, I turn to the theoretical model used at the Brief Therapy Centre of the MRI in Palo Alto as cited by Bogdan (1986).

> ...Problems are thought of as the unintended side effects of usually well-meant efforts to resolve life's ordinary problems. Some solutions have the effect of reinforcing, rather than dampening problem behaviour. This occurs because people frequently do not realize the connection between their efforts to help and the evolution and maintenance of the problems. (p. 35).

Although useful at any level of helping, I think these ideas are particularly meaningful for understanding how larger systems contribute to maintaining the very difficulties they are trying to overcome. Looking at my own presentations in Appendix 1, from repeated conversations with the school psychologist, it was clear to me that his intentions were positive. It was also clear that his manner of viewing the problem did not enable him to realize how he may have been contributing to maintain Fay's behaviour. In Peter's example, the outside agencies may have genuinely believed that Kathy was incapable of succeeding in a residential placement, unaware that

their continuous rejections were reinforcing Kathy's gradual acceptance that she was indeed incapable. Peter also reflected about the difficulties of working in a facility dominated by the medical model of psychiatry. Watzlawick (1984) has pointed out that once a psychopathology is created through diagnosis, a reality is invented in which a "process acquires its own momentum" that can no longer be controlled by the patient or other contributors to the construction of this reality, and that eventually "even the patient accepts as correct and he fashions his life accordingly" (p. 67).

In these situations the characteristics attributed to Kathy, Paula and my client by individuals representing other systems remained fairly stable. Like the orientation one brings to therapy and like the context in which one works, the actions of other professionals and systems interfacing with the client and therapist also contribute to the manner difficult situations are defined and experienced. It would appear that among the participants in this study, only a few were cognizant of larger system issues although they all alluded to some kind of larger system involvement.

### 5.3.5 Summary of the Discussion of the Findings

Each aspect of the discussion in this section has captured a partial interpretation of the meanings of the experience. They have provided an opportunity to view experienced difficulty from different angles, each one separate from and interconnected to the other interpretations. Presented alone, an interesting but insufficient partial picture would have emerged. Together the perspectives provided a choreographed whole reflecting one of many different possibilities of choreographing. For how the meanings were discussed also reflected the imposition of my subjective self on the material. It reflected the past influences on me as a therapist, theoretically and experientially. A different researcher would have certainly discussed and choreographed the material in a manner reflective of his or her training and interest.

## 5.4 Contributions of This Investigation for ~~Providing~~ a Perspective for Understanding the Concept of Resistance in Psychotherapy

The literature on psychotherapeutic resistance was developed in a way that served to explain problematic experiences without first investigating what kinds of meanings were given to these experiences by

therapists. Rather than focusing on experience and its meanings as a starting point, investigators turned away from experience and utilized general, abstract principles for explaining these situations as resistance consistent with whatever theoretical approach one adhered to. This approach generally focused on client or family behaviour as the root cause of resistance. Even when therapists did recognize countertransference issues as affecting the therapy process, they were most likely handled as if they existed within the patient. It is only in recent years that some traditional therapists, most notably Robert Langs, have begun to look at how therapist's way of listening, and organization of client material contributes to the manner in which resistance is identified.

The concept of resistance was constructed at a time when proper psychology was viewed as solely based upon the experimental method and the assumption of rationalism. Based on objectivity, psychological research attempted to neutralize the researchers' experiences from his or her investigations. A reflective attitude was strongly discouraged as the aim was to isolate and manipulate constructed variables.

In this atmosphere, the ideas about resistance

arose. Noted in the literature review was that resistance was generally examined using cognitive models as opposed to experimentation because of the difficulties researchers had in operationalizing this concept. Still the concept has been of major heuristic value in the world of psychotherapy. It has provided a language within the various orientations for talking about problematic experiences in therapy. It has had a practical influence by expanding to include strategies for helping clients and families overcome their resistances (Strean, 1984; Anderson and Stewart, 1984; Ellis, 1985). It has served to place the therapist in an expert one-up position in the therapy process by placing the onus for the problems in therapy on the client or family. Clients often accepted the premise that only with the help of the therapist's expertise could these roadblocks be overcome. They also accepted the premise that this was a process that could take years and sometimes decades.

Robert Langs and recent theorists of systems therapy (Lockhurst, 1985; Keeney, 1983) have described how researchers and therapists cannot help but impose their subjective selves in talking about and explaining resistance. They bring certain biases, ways of understanding and experiences to what and how they

observe and participate in therapy or research. How resistance is defined and whether or not a therapist or researcher will view a situation as exemplifying resistance will be largely determined by one's view of therapy which partially determines how one interprets the experiences lived in the therapy situation.

This investigation returned to a level of examining manifestations of particular difficulty as remembered and its meanings. Therapists were encouraged to reflect upon their experiences and to describe kinds of meanings the experience resonated. I utilized a reflective attitude in my efforts to reveal and to interpret essences of the participants' experiences. The investigation provided a first step in understanding the preconceptual essences of the experience.

## 5.5 Contributions of This Investigation to the Literature Concerned with Meaning in Psychotherapy

This research joins other studies aimed at revealing different meanings of aspects of the psychotherapeutic situation. Viewing psychology as a human science, this investigation evolved from an assumption that not enough was known about the kinds of meanings therapists construct about situations they are

involved in. I accepted the premise that researchers of psychotherapy have placed too much emphasis on experimentation and explanation and not enough on description. I believed that interesting and satisfying explanations could evolve from rigorous description.

This study incorporated a number of the criteria suggested by Barton as characterizing a proper descriptive theory for psychotherapy (see Section 2.8.1). In particular, this study adopted a view thoroughly attentive to the therapist and how he or she provided meaning to the situations. Lacking from Barton's criteria were descriptions of the meanings clients constructed in these situations. Certainly a study that could obtain descriptions from both therapists and clients would be very informative, particularly with regard to the question the extent to which each participant agrees to the meaning provided by the other. However, given that the therapist has generally been neglected in psychotherapy research, this study is relevant in that it moves in a direction that includes the therpist as a topic in research.

As well, this study contributed to the literature on meaning by showing that meaning can be conferred from a number of different perspectives. The meaning-

components revealed in Chapter 4 were discussed from different levels of observation ranging from a persective of an outside observer providing explanations to descriptions he had gathered (Burbridge) to a perspective of a participant-observer providing his explanations of the meaning of his participation (Colapinto).

It is important to keep the levels from which meaning is derived separate from each other in order to obtain a choreographed valid picture of important aspects of an experience. Each level provides a view of the total experience and can add to the richness of how something is experienced.

In structuring this study empirically; that is, in obtaining descriptions from ten experienced psychotherapists, the cross-section of meanings described can be viewed as being consensually valid. Readers will be more likely to agree that these descriptions of difficult situations have some relevancy as presented. Giorgi (1985) pointed out that psychology insists on some degree of empiricism in its studies as opposed to phenomenological philosophy where the researcher often served as the generator of description through imaginative variation as well as the organizer of the data through reflective thought.

## 5.6 Implications of This Study

A major contribution of this investigation has been in utilizing a method that allowed participants to reflect and to describe what happened in a therapy-situation as remembered.

The therapist-participants themselves specified what situation in their range of experiences constituted an experiencing of particular difficulty and provided the reader with a sense of what the nature of their experiencing was through descriptions of their actions, affective-emotional states, attitudes, bodily involvement and biases. The intention of the investigation was to remain with the experience and to allow the flow of the ideas to emerge in the very manner in which they emerged.

In doing so, one got a little closer to an understanding of an aspect of psychotherapy -- not an absolute understanding which is unattainable but an interpretative understanding. The method utilized in the study was consistent with the subject matter I was attempting to understand. Methods chosen to organize the contributions were chosen for their capacity to remain within the experience and elucidate beyond what the participants were saying.

Descriptive research can provide the basis for

returning to a level where experiencing in psychotherapy is investigated and meaning-components increasingly understood. By doing so, it can also encourage the development of theories of change and failure and of the nature of client-therapist interactions in closer proximity to what one actually experiences in the project. In this investigation it became clearer that the manner in which particular difficulty was experienced in a therapy situation was partially common to participants and partially unique. Some of the meaning-components such as frustration and anger seemed to be part of all the participants' experiences. Other characteristics seemed to be closely related to one's orientation and one's work setting.

This investigation served as a stimulus to speculate about how the concept of psychotherapy resistance was invented and utilized in therapy projects, and provided a theoretical framework for explaining a manner of experiencing which hitherto was not described.

## 5.7 Limitations of the Study

An important limitation of the study was that I did not return to each participant to check with each

one whether the identified meaning-components of one's presentation was agreeable to the participant. By asking for their feedback I would have achieved a clearer picture of the accuracy of the meaning-themes. It also would have served to clarify any misunderstandings that may have arisen in participants' descriptions and follow-up elaborations and strengthened the validity of the study.

## 5.8 Future Research

Future research could focus on how therapists experience success in a therapeutic situation and the various meanings which may be present in that kind of situation. Conversely, experiencing failure could also provide an intriguing frame for further understanding an aspect of what it means to be a therapist. Indeed, recently Coleman (1986) published a book presenting eight case studies of failures in family therapy utilizing expert family therapists of various persuasions. The participants each provided a case study of a situation which they viewed as representing a therapy failure.

Each description was previewed by a short explication of his or her theoretical orientation. The descriptive process in my view was cut short in favour

of logical analysis. What were the different ways in which these authors experienced the failure attitudinally, cognitively, bodily? How was this different from their typical experience in therapy?

One exception was a chapter in the book in which a client's experience of failure was presented as described by the client. Perhaps less constrained by theoretical considerations, "Anonymous" provided a detailed description of how she and her family experienced the pain, confusion, and disappointment she, her husband and three children experienced in the situation.

Further investigative efforts should include client as well as therapist descriptions of their actual experiences vis a vis whatever experience one chooses to study. In relation to the present study it would be fascinating to follow it up by investigating how clients and families experience difficulty in a therapy situation or how they experience themselves as being resisted by their therapists. Of particular interest would be to observe how clients' experiences are coloured by their particular schemes of reference.

## 5.9 A Final Reflection

After having read this report of the

investigation, one may ask: How does it contribute to our understanding of the psychotherapy process beyond a revealing of meaning-components which are fairly obvious given minimum reflection?

Therapists rarely give reflective thought to their actual experiencing, so although this investigation focuses on the obvious, the obvious is typically ignored. At the end of the elaboration I asked each participant what it was like to participate in this project. Note how some of the therapists responded:

Debbie: Good. I think the more I think about some of these things with her, the better because this was a tough one for me. I'm sure there will be others so I don't mind thinking about it and get a handle on what would make it easier for me next time if I had to work with somebody like that again.

Tom: ...Well, going back and looking at the experience that I had, the emotional response I had, finding what difficulty was for me in this case because I think this was the most difficult family I ever worked with.

Saul: Well, it was...it wasn't fun. It is one of those things that after you finish it, you can probably say, well, it was probably good for you to do. But it was uncomfortable, too, to review back that kind of distress, but I think it was helpful to review a lot of stuff.... It is a reminder of a situation I was in and in which I felt ineffective and it forced me to look at aspects of myself and things that I've done that I would just as soon forget. That part of it was uncomfortable.

Ken: We don't as therapists spend that much time focusing on our reactions. We certainly live them but we don't focus on them, what we've thought about in session. This is good. This

will make me more aware.

Although some of the participants felt somewhat uncomfortable, there was a general recognition this exercise enabled them to focus on a particular experience in a manner that they would not typically do.

In reflecting upon my experiences in this investigation I wondered how my method of interrogating participants in the follow-up interviews could have been more effective for eliciting more open and frank responses. I chose a direct method of interrogation to gain more information about characteristics presented in the written description. Perhaps if I would have used a method of conversation in which I entered into a dialogue with the participant and in which I was open and frank about my own experiences I would have encouraged participants to also discuss their situations in a free and nondefensive manner. This question arose in my mind, particularly in relation to the lack of reflective thought participants had about the orientations that guided their work in the presented situations. I point to a follow-up conversation I had with Henry in the pilot study and the tremendous wealth of material which emerged. At the time, I recalled wondering whether we were becoming

side-tracked by important but side issues which may be why I chose a direct interview method.

In starting out this venture, I expected to find a way to demonstrate how the experience of resistance was common to therapists across theoretical dimensions. I hoped to uncover characteristics of resistance most therapists could relate to. The study revealed some common characteristics of how participants experienced particular difficulty. However, it also revealed how the experiences were unique to each participant partially determined by their orientation, work setting and awareness of factors such as the role of larger systems in the situation. I now have a clearer understanding about why so many divergent views about resistance are present.

It would have been useful to obtain specific information about what therapists actually did in the situations. Although we do get a general sense of how each participant acted, lacking is a specific description of interactional sequences which could have served to demonstrate connection between meaning and action and to demonstrate what it is that one does that makes or does not make a difference in difficult situations.

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# APPENDIX 1

## Experiencing Difficulty
## A Personal Experience

An example of my experiencing particular difficulty in a psychotherapy situation was in working with a 17-year-old student in a mental health clinic. Fay had written a number of notes with suicide ideation and superficially cut her wrists. I worked with her prior to her first and only hospitalization and following her discharge. There appeared to be a tremendous amount of disturbance in relationships among family members. A year prior to Fay's commencing treatment, her older sister had committed suicide by hanging herself from the bannister in her home. Fay had a brother in jail for reasons that remained unelaborated. She also had a younger sister in her pre-teens.

Fay's mother was described by Fay as being a nag and as someone who did not trust Fay. She repeatedly would query her about drug usage and would reprimand her if she came home too late at night. Mother also provided mixed messages about getting involved in therapy. Father was described by Fay as being distant and uninvolved. My impression from her description was that she viewed him as being irrelevant in her life.

Fay had a boyfriend and the relationship had many ups and downs. He used drugs regularly and Fay stated that she encouraged him not to, at times presenting her wish for him to abstain as a condition for their relationship to continue. At the same time, Fay desired to and did smoke marijuana and drank occasionally and always felt guilty for doing so, particularly toward her mother. She would lie about using drugs and feel even worse about it. (It is noted that much of the above information was elicited in latter sessions of therapy. In early sessions, Fay would volunteer very little information about herself, her difficulties or her family.) Fay also ate very little and demonstrated symptoms of being anorexic.

Fay was referred to the clinic by the school psychologist, who, in my mind, was a key actor in the situation. She was referred after she had written a note with suicide ideation, which had been delivered to the school principal by a friend of hers who then consulted with the school psychologist, Ted. As it turned out, Ted was already deeply involved with Fay and had been for a number of months. He saw her on a daily basis in his office, including frequent occasions when she should have been in class. He accepted phone calls from her at home seven days a week and all hours

of the evening. When Fay had gone to Disney World with her family, she called him collect to tell him how depressed she was and he accepted her call. He appeared to collude with Fay about keeping information about her self-destructive thoughts and actions from her parents as well as in not referring her to the mental health clinic at an earlier occasion. Immediately, I recognized that Ted was part of the problem and would have to be considered and worked with in an active manner.

In the first session Fay, who was brought to the clinic by Ted, presented herself in a manner that appeared to indicate that she was very unhappy. She looked towards the floor most of the time and made very little eye contact. She was guarded in providing information although she did state that she was feeling guilt and great unhappiness about the circumstances of her sister's suicide, whose anniversary date was rapidly approaching. She also expressed anger about how her mother had tried to protect her from finding out about her sister's death until a few days later. She was told, on the day of the suicide, that she would be sleeping at her grandmother's and nothing else was said except that her sister had hurt herself. She felt she was treated like a baby. She also stated that the

topic of her sister's death was not discussed at home. My intervention was to normalize her feelings, particularly with the anniversary approaching and to suggest that her mother come in next time so I could get additional information. Fay was adamant about not involving her mother and so I agreed to see her individually.

The second appointment was postponed a couple of times by Fay. She would get Ted to call for her to postpone or she would do it from Ted's office in his presence. Finally, Fay was brought to the clinic by Ted during class hours as she continued to write notes to Ted that included statements about hurting herself. She said very little, sitting, staring at the ground, sometimes biting her nails and occasionally giving me a glareful look. She did agree to sign a contract agreeing not to hurt herself for a period of time while we worked together. Again, I recommended that her mother and other family members take part in the next session but she continued to veto the idea, claiming her mother didn't really care about her.

The third session also was postponed a number of times with different excuses and Ted's active involvement. Finally, I agreed to come to the school for the session. Fay stated that she found it

difficult to talk that day and then closed her mouth. My response was to take a pen and paper and I wrote that I didn't want her to say anything further that session and I asked if she would answer written questions in a written manner. She agreed. She proceeded to give long, elaborate answers to my questions. Fay restated her anger toward her mother and expressed feelings of helplessness that anything could change in the relationship. She also expressed anger toward her boyfriend and she stated that the only people in the world she felt were truly trustworthy was Ted and myself. I thanked Fay for the productive manner in which she had responded to my questions and I did so in a written manner.

Between the third and fourth session a friend of Fay told the psychologist that Fay had brought a bottle of pills with her to school and was thinking of taking them or she had already taken some. She was brought that day for a session and at that point I insisted in getting her family involved and that I would be calling her mother to set up an appointment. I stated that we really did need her help in this situation. Fay volunteered that her mother and she were going away together that very weekend and she requested a chance to work on their relationship her own way during the

weekend and she agreed to involving her mother in the future if it didn't work out. I agreed and another appointment was scheduled for one week later.

A week later Fay came for her appointment and presented herself in a totally different manner than in past sessions. She was dressed impeccably and looked radiant. She was in a definite upbeat mood. She reported that the weekend had gone wonderfully well. She reported that a new understanding had been reached with her mother. They had spoken openly and honestly and Fay felt very good about their relationship. She furthermore rejected any future self-hurting actions. Although expressing delight at this turn of events, I also expressed amazement at this sudden change and I cautioned her that although the relationship between her mother and herself appeared to be significantly different, there would probably be some bumpy times ahead and that it would be useful for her to prepare herself for those difficult moments. To myself, I was somewhat skeptical about these turns of events and I did not expect this difference to last. A follow-up appointment was scheduled for two weeks later.

Again, Fay arrived looking radiant and expressing no additional difficulties with her mother or in any areas of her life. I began to believe that perhaps

something significant had indeed occurred and perhaps Fay was indeed over the hump. An optional appointment was set up for one month later. Fay did not keep her appointment and the school had no further concerns about her. Subsequently, I closed her file.

About two months later I received a call from Ted reporting that Fay had self-administered superficial lacerations on her wrists. The evening before she had called Ted at home and told him that she had cut herself and again Ted had not notified her parents. He also reported Fay was again spending a tremendous amount of time in his office during the school day. Inside, I was angered over his not informing the parents. Why was he behaving in what I considered to be a totally unprofessional and inappropriate manner? How is it that he had not taken any steps to meet with Fay's parents and let them know what was going on? To me, his behaviour was awfully strange and detrimental in this situation. Didn't he know he was playing with fire? On a number of occasions I and my supervisor had met with Ted and tried to show him how Fay, having free access to him day and night, was not helping her and that he should allow the clinic to do the therapy without his being involved. Him being a peer, we approached him in a subtle manner and although he would

acknowledge what we were saying and stated that he would refer all issues related to her difficulties to me and not allow her to talk about them with him in his office, he also clarified that he thought the friendship that had developed between them was important to her well-being and he would continue to be accessible for her at that level. Following those sessions with Ted, I would have a sinking feeling, being aware that he was a major part of the problem and wondering what to do next. I was also outraged by his behaviour and on occasions considered the possibility of writing to the ethics committee overwatching school psychologists to register a complaint. I became very suspicious about the nature of the relationship between Fay and Ted and somewhat helpless about what to do next. If this had not been a public agency and I had not been an intern, I may have considered withdrawing from the case because of the complexities of the larger system issues. However, that was not a realistic option at the time.

Given the administrative procedures and sensitivity of the school system and Mental Health when suicide ideation was involved, I had no choice but to see Fay the same day as the phone call. I anticipated Fay's arrival by wondering if she needed to be

hospitalized and by deciding that I would insist on her parents' involvement from the outset to make them aware of her situation, to enlist their help in monitoring Fay's behaviour at home and to obtain additional information about family relationship patterns and how Fay's behaviour fitted into the pattern.

Fay arrived to the clinic and acted in a similar manner as the very first time I had seen her. She did not want to talk. She volunteered very little information other than to state that she hated her mother and that she could never trust her again. She kept her eyes away from mine and sometimes glared at me when I "pushed" her hard. She did not deny that she had had thoughts of hurting herself. When asked whether she thought she should be hospitalized, she replied "no". However, I stressed that that was a very real option in the near future. In evaluating her for suicide risk, I was uncertain but decided that she probably wasn't at risk at that time so I did not recommend hospitalization. At the same time I wasn't totally comfortable with my decision. I told Fay that I would be contacting her parents to ask them to come to the next session scheduled for next week. I also stated that they had to be informed of her actions and she asked to do so herself and I reluctantly agreed

that she inform her parents on her own and she agreed to do so in the next two or three days.

Later in the same day I conferred with my supervisor about the case. I felt very uncomfortable that no information had been relayed to her folks to date by the school or ourselves. Part of the difficulty was that Fay was 18 years old and so the issue of confidentiality had to be considered. Conversely, this could be waived if Fay was viewed as being a danger to herself or others. The more we discussed the case, the greater discomfort I felt about having given Fay additional leeway in agreeing not to discuss what had happened with her mother that very day. Was I falling into the same traps Ted had fallen into; that is, colluding to keep her family out of the picture? As well, I wasn't totally convinced that she wasn't at some risk. I knew that in the past she had gone as far as hanging a blanket from a tree and was stopped by her friends from hanging herself. Even if she wasn't at risk and even if it was what many people like to refer to as "acting-out" behaviour, it could be useful to up the ante by taking her behaviour very seriously and hospitalizing her. I thought that if she was hospitalized and it was acting-out behaviour, then hopefully she would find the hospital experience so

nauseating that she would stop acting in a self-hurting manner. If she was suicidal, then the hospital would be the place where she would receive the closest amount of supervision. As well, thinking retrospectively, by inducing a crisis, perhaps the family would then be "open" to external interventions.

I spoke with Fay's mother that afternoon and passed on information about Fay's wrist-cutting behaviour and the notes she had written. Her mother expressed a great deal of concern and asked what they should do. I stated that I felt family members should monitor her behaviour closely. If she or other members felt concerned about Fay's behaviour and that she was at high risk, they could take her down to the emergency room at the local hospital and have her evaluated. I left them the phone number and address of the hospital. As well, an appointment was scheduled for Fay and family members for early the following week. Mother expressed her anxiety to me and asked how she could trust Fay to be alone. I empathized with her and stated that Fay would need close supervision for the next short period of time.

In the end, Fay was taken to the hospital by her parents that same evening and voluntarily signed herself in as a patient. She remained in the hospital

for eight days. Her mother called me on a couple of occasions and each time she expressed her amazement that nobody in the school had informed her what had been happening throughout the months and she was particularly upset with Ted's not notifying her during that time. I strongly suggested that she state her concerns with the proper authorities at the school and Ted and during the conversations I tried to reinforce my need for her help in my work with Fay after she would be discharged. She agreed to attend the sessions and stated it would be difficult for her husband to come, too. Later on it became clear that mother and Fay "colluded" at some level to keep her husband away from the sessions.

It was at this time that I received quite an education about the workings of a psychiatric unit of a hospital. I expected that within two or three days of her hospitalization somebody from the hospital would contact me to get additional information about the case and to find out what had been attempted to date in my work with Fay. To my absolute surprise, nobody contacted me and nobody attempted to contact Ted at the school. As well, Fay's mother, who had visited with Fay on a regular basis, was not asked to be seen by the psychiatrist or social worker and was basically ignored

although she had been there while the attending psychiatrist was making his rounds. This startled me, for wouldn't the staff be interested in obtaining additional information about the case from people who knew her the best and from people who had been working with her over the past number of months?

Finally, I initiated contact with the social worker and staff psychiatrist on the ward. I discovered that their interest was less of a clinical nature and one ensuring arrangement for post-discharge care. My main contact was with the social worker assigned to the case. The attending psychiatrist spoke to me only once when Fay, after five days of hospitalization, requested to revoke her voluntary status a couple of days prior to her planned discharge. To that end, Fay had also contacted me by telephone and Ted, to ask whether we thought she should proceed or stay an extra few days on the ward. After speaking with the doctor, who explained that Fay had been placed on anti-depressants and it was preferable that she remain in the hospital another few days to enable the medication to take effect, I phoned Fay back and recommended that she remain in the hospital the extra few days. This was also a position that her mother agreeed to, and Ted. The doctor also felt that

mother was a source of difficulty for Fay although I don't remember the exact context of his words. His words strengthened my conviction even further that family therapy was the treatment of choice for working with Fay.

During this period, Ted remained "intimately" involved with Fay. He visited her frequently at the hospital and accepted all her phone calls at school or at home. I knew that he wasn't going to disappear and that something had to be done about him. After consulting with my supervisor, I decided that I would incorporate Ted as a co-therapist in sessions with Fay. I would get him as involved as possible in the process. My supervisor did not totally agree with this approach and suggested a more confrontative approach with Ted in order to stop him from interfering. Given my position as an intern without much hierarchal authority, given that Ted was a peer in the same profession as I was, and given the conviction that a more complete incorporation would have a greater effect on modifying Ted's behaviour hopefully turning him into part of the solution, my supervisor agreed to support my position and I proceeded. I met with Ted prior to Fay's discharge and he agreed to take part in the therapy sessions. However, he expressed concern about

harming the relationship that had been established between Fay and himself and he would not want to do anything that could effect their friendship.

Upon listening to his words and observing his non-verbal behaviour, my opinion of this person's professional skills hit rock bottom. I would think to myself, where was his professional demeanour? What kind of idiot was he? Didn't he know he was doing more damage than good? Every time we had met to discuss the case, Ted would sit slumped in his chair, always looking as if he was on the verge of crying. One strategy that my supervisor and I had attempted was to acknowledge how exhausted Ted must feel from all the time he was spending with Fay. Ted acknowledged that but he felt this was the way he had to work. Indeed, since we had become involved with Fay, two other females at the school had begun to write notes and cut themselves and spending a lot of time at Ted's office. Even a "suicide club" had been formed as a support group in which four or five pupils attended. However, the principal of the school put a stop to its meetings after two sessions. I could not believe Ted's enmeshment in this case and his total lack of insight into how his behaviours were not helping matters. Clearly, he was not hearing our ideas for doing

something different. I hoped that in being a co-therapist, Ted would learn to establish some boundaries between himself and Fay and discover more effective ways for working with Fay. This did not occur. Save for some limp attempts to support my interventions, he sat in the room and did very little. He would fidget uncomfortably whenever I took a more confrontative position. On one occasion he reported that Fay had told him something that he thought was very important that she tell me but she made him promise not to tell me and he spent a good part of that session trying to convince her to tell me, which she adamantly refused to do and she repeatedly reminded him that he promised her that he wouldn't tell me. It seemed like a three-ring circus and after letting this pattern continue for too long, I encouraged Fay not to tell me and refocused our efforts to something different. Another shock for me was that I often found Ted talking with Fay in the parking lot sometimes 45 minutes or one hour after the session had been completed. The situation was absolutely ridiculous! And what more could I do about it? If I had been cautiously optimistic at the beginning of the co-therapy venture, it rapidly faded two or three sessions later.

Following Fay's discharge from the hospital, I saw

her for four or five sessions until she dropped out. In the first session Ted and Fay's mother attended. Mother expressed her concern about Fay's unhappiness and repeated need to resort to self-hurting behaviours. At the same time, she was guarded and ambivalent about a number of areas I wanted to touch, including her daughter's suicide, son's jail term and her husband. She gave many reasons why she didn't think her husband would be able to attend sessions, including a single session where I could obtain his perspective of what he thought was causing Fay's behaviour. Mother did admit to thinking that perhaps she was over-protective of Fay but that was about as far as she would go. Although mother committed herself to attending additional sessions, this was the only one she ever attended. Fay attended the next session and other sessions, stating that her mother did not want to attend any additional sessions as there were things she did not want to talk about. I expressed my respect for her wishes to Fay and agreed not to touch areas she was sensitive to and asked Fay to relay that to her mother but still she refused to come. Clearly, this was a very secretive family and they were not about to expose their dirty laundry to anybody. It was also clear from earlier and later sessions that Fay was very respectful

of this rule.

During that initial session after hospitalization, Fay appeared to be in a much better frame of mind. She was more verbal than usual and volunteered more information than usual. She stated that the hospital experience had been terrible and that she had been mixed in with all kinds of odd people and that she intended never to go back there again. She felt she was better equipped to handle her difficulties than before although she was vague as to how she would do so and most importantly she realized her mother really cared about her. She planned on completing high school that year and probably pursue her plans of going into nursing school the next year. She was dressed nicely, smiled frequently and seemed motivated to continue in therapy at this junction. At this point, I felt quite positive about the therapy process. Fay appeared to be involved. Mother appeared ready to be involved. I even thought I could handle Ted and create a joint venture in which Fay would be getting the same message from both Ted and myself. I felt confident and hopeful this time that something genuinely could be done to impact Fay and move her away from her dysfunctional behaviour patterns.

I was investing a tremendous amount of time and

energy in this case, far more than any of my other cases. I would talk extensively with my supervisor about it. I would seek out ideas from professional books about how to proceed. I often thought about the case after hours. Sometimes I would lie awake at night and think about it or even dream about what had happened. I found myself wound up by anticipation prior to the session, not always in a positive way. During the session, I would strain to pick up everything that was occurring, trying not to miss a word, a gesture, a moment. By the end of the session I was totally drained and ready for a long break. Sometimes I felt excited and sometimes I felt helpless about the situation.

In the second session following her discharge, neither the school phychologist nor Fay's mother attended. However, these 45 minutes are best described as a moment when the sky opened up and Fay really let me into her world. Fay opened up and discussed important problem areas in a frank and detailed manner. Her voice was quiet and mannerisms somewhat resigned-looking as she spoke. In particular, she was disturbed by her feelings of guilt about her sister's death and feelings of guilt whenever she didn't obey her mother's expectations of her. She was terribly

angry about how she felt she was being treated by her mother (like a baby), in her mother's lack of trust in her, and in her having to resort to lying whenever she did something contrary to her mother's wishes. She never let her mother know about her anger and instead felt tremendously guilty about her actions even when Fay herself thought it was okay "to do those things". During most of the session I sat back and listened. It was like the opening of a dam. At the end, I expressed my appreciation of the difficulty for her to express her thoughts and feelings and I stated my hope that mother would attend the next session so that we could work together on the difficulties she had mentioned. (I did not know at the time that Fay's mother would not be attending any further sessions.) I don't recall giving her any prescriptions. I know that I was ecstatic following this session. I kept smiling to myself. My body was alive, my mind shifting from thought to thought. I thought that indeed it would be possible to help Fay, particularly if Ted would continue not to come to sessions and if Fay would attend them regularly.

In the next session, as quickly as the dam had opened, it shut down again. I had arranged with Ted not to come to the next session and to provide Fay with

a reasonable excuse. In retrospect, I don't think that Ted was totally agreeable to my request for now that I think about it, he seemed to indicate in different ways that he was indeed interested in coming. On the day of the scheduled session, Ted called me and told me that he had told Fay that he would be unable to make it because of an unexpected meeting. Her response was to suggest that she wasn't sure that she could attend that day either. I asked that she call me directly. She didn't contact me nor did she show up for the session. I felt extremely frustrated at that point. What had happened? Why didn't she come, particularly in light of the previous session which had gone so well? I knew then it was premature to exclude Ted and he was invited to take part in the next session. Now that I reflect upon it, perhaps there was an issue of loyalty here where Fay may have, at some level, experienced herself as being disloyal to Ted if she would attend another session without him.

In the next session attended by both Ted and Fay, Fay was tightlipped again. She stated that she didn't even know why she was coming. Any attempt by me to discuss anything were met by terse, one-word answers or glares. She appeared to be terribly angry and wouldn't talk. This was the session in which she had told Ted

the secret prior to the session and made him promise not to say anything to me. She continually exchanged glances with Ted and as I mentioned earlier, Ted tried to convince her to tell me the secret until I finally redirected the session. I remember feeling absolutely frustrted with Fay, angry with Ted and generally helpless during the session. I know my hands were wet and I felt tense in my chest area. At times I found that I couldn't think straight. Indeed, I found myself changing theoretical orientations a couple of times in the session in a totally inappropriate manner. T continued to behave in a very hostile manner and Ted just sat in his chair in a very limp manner. Finally, I asked Fay to leave the room and I spoke with Ted alone. I stated that it was crucial that this kind of collusion not happen again and that Ted insist that Fay not bring up any topics related to therapy in whatever other conversations they may have with each other. Ted agreed and then left. I felt quite devastated after this session. The case was going absolutely nowhere. I was angry with Ted for starting this charade and with myself for perpetuating it. The therapy seemed to be having no impact on Fay and whatever possibilities that seemed to exist after the previous session were now gone. I was not succeeding in engaging her mother and

Ted was as enmeshed as ever.

I left the building about thirty minutes later and there were Ted and Fay conversing in the parking lot. Again, I just couldn't believe it. I went home drained and wound up and was up thinking about the case at least until midnight.

The next session was cancelled by Fay through Ted and then Fay arrived the following time for what turned out to be the last session I'll have with her. Ted had notified me that he would be unable to make it. Fay looks preoccupied and after about two minutes asks if she could leave, as she has to see her boyfriend, who is in the laundromat next door. They had had a fight the previous evening and she just had to see him. I tell her that it is her decision and I respect whatever she decides to do. When she got up, she asked if we could schedule an appointment for next week and I answer yes. Prior to leaving the room, she stated that she was re-considering nursing school and thinking of going away to a four-month program during the summer. Then she left. She did not show up to the next session and because my internship was rapidly coming to an end, the case was closed by the clinic. Prior to doing so I sent her a therapeutic letter focusing on her strengths, acknowledging her fierce independence, pride

and respect for her family and wishing her the best in the future. I had also sent one or two therapeutic-like letters to her mother after she stopped coming, the first asking her to continue in therapy as I needed her help in working with Fay. The second one, I do not recall the content of the letter.

At the time that my involvement in the case was terminated, I recall thinking that not much had occurred and as long as the key for dealing with Ted was not found, there would be very little a therapist could do for Fay. I believed that she still needed help and feared that one day she might indeed make a serious attempt on her life. Part of my sadness had to do with all I had invested in this case at different levels and what the outcome appeared to be. Having a systems orientation, I think I was aware of different elements that had to be considered and effectively dealt with. It was very difficult to actually do what needed to be done given the sensitivities in the different systems and at different levels, my own position in a hierarchy and the freedom that I actually had for doing what I believed needed to be done.

# APPENDIX 2

## DEBBIE'S WRITTEN DESCRIPTION

DESCRIPTION #1

DEBBIE

I experienced ongoing difficulty in my work this past year, being the therapist for a 23-year-old Caucasian female client who was in outpatient treatment at the psychiatric clinic where I was employed. The clinic is an outpatient unit of a State Psychiatric Hospital and the clinic is located in Ulster County, New York. The focus of the clinic is to treat the more chronic clients in this county, and that often translates to mean the clients with less motivation for treatment. In general, less financial and emotional stability in their lives.

This particular client, who I will refer to as Janet falls into the classification of the young chronic adult psychiatric client. She has had only one psychiatric inpatient hospitalization in her life, at age eighteen years; however, she has been in psychiataric treatment since age sixteen years and did spend one entire year at a residential school for emotionally disturbed adolescents.

She was referred to our clinic from the local mental health clinic due to need for outreach

services. She had been treated at their clinic for three years and was no longer keeping appointments or complying with treatment. They saw her as needing a more outreach and comprehensive approach to treatment, including case management services. I was assigned to be her therapist about one year ago. I did not find her need for outreach difficult. We have state cars available for such situations and I did not mind visiting her in her apartment or in the town where she lived. What I did find frustrating were the changes in her personality, which eventually became predictable but which always felt like receiving a curve ball. On the one hand, Janet acts like an adolescent in need of mothering. She is fearful of people (boyfriends, girlfriends, landlord and the police) and confided her fears and needs to me as her therapist. She is then very appreciative of help and I felt that I was beginning to have a trusting relationship with her. However, within the next week, she could become very angry, hostile, etc. towards me and the so-called relationship I thought I had with her meant nothing.

For example: At one point in the therapy she was being exploited by some local male street people. She was letting them into her apartment and then was robbed and beaten, etc. She did report this to the police but

in the meantime I placed her at the crisis residence until she could find more appropriate housing. While at the crisis residence, she continually ignored the rules and was finally asked to leave. When I tried to mediate the situation with CR staff, I saw that Janet lied repeatedly about her behaviour just because she didn't want to follow the rules. It became harder to be her advocate in any situations, as I knew she often lied with other people just to get her way.

She also lied to me in therapy. It was this that bothered me so much, her turning facts her way whenever faced with a situation she didn't like. I began to see that, in addition to her mental illness, which does, at times, cause her to be fearful of others and become paranoid. (These symptoms are controlled by and large by medication), her personal code of ethics allowed her to lie, throw temper tantrums and essentially do anything she felt necessary to get her way. This often meant physical and verbal fights with others. I began to experience Janet as a 27-year-old who in many situations acted like an extremely younger person who had no remorse about aggressive and hostile actions to others. We would talk about this in our sessions. Janet was often quite pleasant and buddy-ish in our sessions but I didn't see myself having any effect

whatsoever on her decisions about the way to deal with the world. She would be nice to me or from me (support, etc.) but this in no way influenced her modus operandi, which I now feel borders on the criminal. I felt no trust was really building that would have any effect on her psyche. She continued to use mechanisms of projection and denial in her dealings with others, and often seemed to have no conscience. There was no personal core there that I thought would help her to start developing insights into her faults and work towards becoming more mature. It was almost as if she had decided some time along the way in her development not to accept any of the bad consequences of wrong behaviour. I found this trait very frustrating, as it eventually nullified our work together. I didn't find her more flexible or willing to listen to another way, but rather saw her stuck in a groove which was comfortable and which she had no motivation to change. She has been personally arrested and spent a few days in jail but her family bailed her out. I think she will be there again and may finally decide to change on fear of repeated punishments like that.

I actually saw her as a person without a conscience and how do you work with that??? Very difficult for me, particularly with her having a rather

innocent, secret side to her. This is real but not the stronger part of her.

So, in summary, I wouldn't advocate for her, such as in her living situation (CR) because I often knew that she was in the wrong. The relationship seemed to make little difference to her decisions about behaviour. And I felt the futility of verbal therapy in someone who will seemingly not benefit from it. She did, however, ironically comply in the treatment in that she came in regularly for her medication and did keep a good number of appointments with myself and her psychiatrist.

# APPENDIX 3

## FOLLOW-UP INTERVIEW WITH DEBBIE

Follow-Up Interview with Debbie

Debbie: (Starts to read) I experienced ongoing difficulty in my work this past year being the therapist for a 27-year-old Caucasian female client who was in outpatient treatament at the psychiatric clinic where I was employed. The clinic is an outpatient unit of a State Psychiatric Hospital and the clinic is located in Ulster County, New York. The focus of the clinic is to treat the more chronic clients in this county, and that often translates to mean the clients with less motivation for treatment and in general, less financial and emotional stability in their lives.

This particular client, who I will refer to as "Janet," falls into the classification of the young chronic adult psychiatric client. She has had only one psychiatric hospitalization in her life (comments) which makes her a little unusual in that category (continues to read) at age eighteen years; however, she has been in psychiatric treatment of one kind or another since age sixteen years and did spend one entire year at a residential school for emotionally disturbed adolescents.

She was referred to our clinic from the local mental health clinic due to need for outreach services. She had been treated at their clinic for three years and was no longer keeping appointments or complying with treatment. They saw her as needing more outreach and comprehensive approach to treatment, including case management services. I was assigned to be her therapist about one year ago. I did not find her need for outreach difficult. We have state cars available for such situations and I did not mind visiting her in her apartment or in the town where she lived. What I did find frustrating were the changes in her personality, which eventually became predictable, but which always felt like

receiving a curve ball. On the one hand, Janet acts like an adolescent in need of mothering. She is fearful of people (boyfriends, girlfriends, landlord, and the police) and confided her fears and needs to me as her therapist.

I: Let me stop you here. Tell me a little bit more...you found her frustrating and you said it was like being on the receiving end of a curve ball. Tell me a little bit more about how you experienced that.

Debbie: Well, I would begin to think that we had a relationship and that perhaps she would call me when she got into trouble or she wouldn't do some of the things that she did just because of the relationship, and I found out that the relationship had no influence on her behaviour.

I: What kinds of things do you recall saying to yourself in face of this frustration? Any kinds of body reactions, tensions, or anything like that?

Debbie: Well, I think when I would get angry with her I would just kind of distance myself from her. I would get more formal, less sort of buddyish and I would sort of step back into the role and be more formal when I got angry. What else did I do? All sorts of terrible thoughts (laughs).

I: Do you remember what kinds of thoughts?

Debbie: Well, I began to think that she had no conscience and that really bothered me. I guess she touched off things that tend to be my pet peeves, which are people that have slightly sociopathic behaviour. I mean, that is a term, but when you deal with someone, you see they really don't have a conscience. I mean, nothing really bothered her and that lying didn't bother her at all and that bothered me. I don't want to have a lot to do with you if you're going to lie. Not so much to me, but to other people.

I: You said, "sometimes I get really angry when

she was like that". What was it like feeling angry?

Debbie: It didn't bother me. I just knew I was angry and I would talk to somebody about that and...I would mostly go and talk to the case manager and tell him how angry she was making me. I would also talk to the psychiatrist but the psychiatrist seemed to feel that she was doing all right because she was taking her medication. I mean, she seemed to see her in more of a positive light than I did. She was complying with the rudimentary parts of treatment, which is that she was keeping appointments with her and she was taking Prolixin shots.

I: Were you able to feel your anger anywhere in your body like a flushed sensation or...?

Debbie: No. (Continues to read) She is then very appreciative of help and I felt that I was beginning to have a trusting relationship with her. However, within the next week, she could become very angry, hostile...towards me and the so-called relationship I thought I had with her meant nothing.

I: What was it like dealing with her inconsistency? On the one hand there seemed to be a close relationship and on the other hand...

Debbie: Well, the truth of the matter is, she didn't get angry with me very much. I didn't get the brunt of her anger and lies and all of that. I think one or two times she would come into my office and be angry at me and usually I could get her to sit down and talk to me, so it wasn't so much that she acted out with me. It was what went on in the rest of her life. So, that didn't bother me so much and I guess that is what made me think that I was having a relationship there because I could get her to calm down, we could talk about it. She would talk to me very sensibly. She would show some insight into things and then she would go ahead and start a fight in the community residence where she was living, hit somebody over the head. Let me see, the first really

frustrating thing that happened was she had no place to live. I placed her in the crisis residence. She broke the rules and denied breaking them. She lied about breaking them. She ran away from there. She just didn't...she did terribly and she came back to me and wanted me to advocate for her. She told me that they were lying and that she hadn't done a lot of this stuff and I went to a meeting with her present and it became very clear how she dealt with people when she was confronted. She lied and denied and she did this at the meeting and I saw that we were getting nowhere because she didn't accept any responsibility for what she had done there. She smoked upstairs when she wasn't supposed to. She used the telephone, too. She just basically broke a lot of rules and when confronted with them, she started calling them liars. I mean, she showed no insight, so the insight she showed in sessions with me didn't carry over to other parts of her life. So, I saw that I was working with somebody who might come in and sort of sound good but out in the world did not do well at all. I think the lying aspect of it was what really bothered me about her.

I: How was it bothersome for you?

Debbie: She didn't take any responsibility for herself, not for her actions, for that's not so trite, but she wants a lot. She wanted a lot from people. She wanted a lot of special considerations. She wanted to smoke upstairs even though she wasn't supposed to. She wanted to do things that she wasn't supposed to do, so instead of not doing them, what Janet does was that she went ahead and did them anyway and then when confronted with it, she would lie and sort of turn the whole situation around so that it looked like she hadn't broken any rules but in reality she just did not want to not do anything she wanted...she wanted to do what she wanted to do and I felt that that was wrong because she was stuck. She really came to us for lots of practical things, like a place to live, and then she would get into this situation just because they weren't doing things the way she

wanted, and then lie about it, so I felt...

I: What kinds of feelings were going on for you when she was doing these kinds of things?

Debbie: I was angry at her. I thought she was acting more like a three-year-old in a 27-year-old body and wouldn't accept it all so she turned everything around so she had no part in it. She was good. The other thing that bothered me too was that she hurt people physically. She's physically assaultive to people and she would also deny that and she would lie about it, so she is a person who wants everything the way she wants it. She'll hit you if you don't give it to her and then she'll lie about the whole situation and see nothing wrong with it. (Continues to read) For example: At one point in the therapy she was being exploited by some local male street people. She was letting them into her apartment and then was robbed and beaten, etc. She did report this to the police but in the meantime, I placed her in the crisis residence until she could find more appropriate housing. While at the CR she continually ignored the rules and was finally asked to leave. When I tried to mediate the situation with CR staff, I saw that Janet lied repeatedly about her behaviour just because she didn't want to follow the rules.

I: "She lied repeatedly." How did that effect you, knowing that she was lying?

Debbie: I got annoyed. It was a coward's way out. It was as if at least she should...well, near the end of therapy she started admitting to me what the truth was and then we would talk about how she turns things around so that it works for her benefit, but it is frustrating. You feel, with you, she should always be truthful. She would re-arrange all the events so that she wouldn't look at all as if she was guilty and then if I am going to advocate for her, then I can't because I am basically going to advocate for somebody who is untruthful, so there goes that down the drain (laughs). Really, you can't...

I: She made it hard for you to...

Debbie: Yeah, it made it harder for me to be on her side.

I: How did you experience that you were unable to be on her side?

Debbie: Well, very frustrating because I began to feel like she deserved what she got and then it is hard to help somebody when you feel that way. (Pause, then continues to read) She also lied to me in therapy. It was this that bothered me so much rather than her turning her facts her way whenever faced with a situation she didn't like. I began to see that in addition to her mental illness, which does at times make one fearful of and become paranoid, these symtoms are controlled by and large by medication. A personal code of ethics allowed her to lie, throw temper tantrums and essentially do anything she felt to get her way. This often meant physical and verbal fights with others. I began to experience Janet as a 27-year-old who in many situations acted like an extremely younger person who had no remorse about aggressive and hostile actions to others. We would talk about this in our sessions. Janet was often quite pleasant and buddyish in our sessions but I didn't see myself having any effect whatsoever on her decisions about the way to deal with the world. She would be nice to me or from me (support, etc.) but this in no way influenced her modus operandi, which I now feel borders on the criminal.

I: What was that like having those kinds of feelings while working with her?

Debbie: Well, just sort of like you become cynical. I really felt that she got what she deserved because I felt like she was going to act it out and throw things at people and hurt them and she physically assaulted one of the counsellors at the community residence where she was living and then denied the whole thing. Then I felt that she should really be treated more as somebody who was breaking the law than as a psychiatric client, for I didn't

see it as anything that had to do with her illness. It had to do with her wanting to have her own way and not being able to control her physical aggression. I don't think that had much to do with her illness. Her illness makes her paranoid and fearful. She has had auditory hallucinations but the acting out behaviour was more in wanting things from people and wanting attention more than just sort of being...

I: When you were feeling cynical toward her and frustrated, mistrusting, what did you do with that?

Debbie: Mostly talked it out with the case manager. I really gave him an earful. And also, with the psychiatrist to a certain extent. Mostly, I would talk to people about it and just, you know, not do much about it and her family because her parents had gone through this for a number of years and I had a long talk with her mother one day about it. I mean, I didn't express my anger with her mother. It was somebody that understood what I was talking about.

I: So, you more or less talked about it with other people who were more or less intimately involved with her?

Debbie: Yes. (Continues to read) I felt no trust was really building that would have any effect on her psyche. She continued to use mechanisms of projection and denial in her dealings with others; and often seemed to have no conscience. There was no personal core there that I thought would help her to start developing insights into her faults and work towards becoming more mature. It was almost as if she had decided some time along the way in her development not to accept any of the bad consequences of wrong behaviour. I found this trait very frustrating as it eventually nullified our work together.

I: Tell me a bit more about your frustration with this trait. What kinds of things were happening for you?

Debbie: Well, I began to see this as something she had learned in her family and the more I found out about her family history, there was...to me it made a lot of sense that her father had acted this way a lot and that this was just a lot of just role-modelling from parents and I don't feel sympathetic to it. It is sort of like, "well, you can go ahead and do all these things. You are going to have to pay a price for them". And I didn't feel that verbal therapy was what was going to help her with this problem. So, I stopped talking to her about it really that much. Well, I did really continue to talk to her about it because she was very compliant with me but it didn't effect her behaviour. She came to me once when she was being asked to leave the community residence and she said, "well, I want to leave and they are asking me to leave and they started..." She recalled the incident and she had made it sound like they had started this whole thing with her so she wanted to leave and I felt frustrated because I knew she wasn't going to make it out on her own. She hadn't before and yet I knew there wasn't very much I could do to help the situation at the community residence so it was kind of like, well, that's the way it is.

I: You've mentioned the term frustrated a lot. It seems like it has been a major part of your experience with this girl was the frustration. How did you know in this particular case that you were feeling frustrated? What kinds of things were going on for you?

Debbie: Um, I would get a phone call from the community residence telling me about this, this and this, and I would be really upset to hear all of this, of what she had done and that is how I would know that I was frustrated.

I: When you say upset...

Debbie: Do you mean like do I feel it in my body, upset?

I: Yeah.

Debbie: My voice gets louder and I sigh and I, it is sort of a feeling of resignation, you know, ach, not again, powerlessness, I can't help you, I can't do anything to change her so don't look at me. I know I am her therapist but I can't help it.

I: So, part of your knowing that you are getting frustrated is that there is change in your voice?

Debbie: Yeah.

I: Louder or higher?

Debbie: I think I just sort of get repetitive. I end up repeating things about three or four times, sort of in an angry, whiny tone and then I sigh a lot and I think that that's my way of feeling frustrated. I do end up repeating things a lot. I know that.

I: Like an "oy"?

Debbie: Yes, like an "oy vey". No, actually it is more of a "if I can talk about it enough, I won't feel so angry". Unfortunately, the person who is listening to me finally says, "listen, I've heard that a few times already".

I: Those are obvious cues to you that certain things are happening for you in relation to this client?

Debbie: Not really. I think that that is the reaction. I don't need cues. The cues when I'm getting angry; I know when I'm angry. I think the body stuff happens afterwards. Like, I'll have an angry thought and the body will go along with it and the voice will go along with it.

I: How does the body go along with it? Do you mean the sighing or do you mean in other kinds of ways too?

Debbie: No, your voice changes and you might walk here or there or walk around and stuff (laughs) and just the tone of voice that you'll go talk to

somebody else about it. You'll get this energy up to saying something else to somebody sighing a lot. (Continues to read) I didn't find her more flexible or willing to listen to another way, but rather saw her stuck in a groove which was comfortable and which she had no motivation to change. She has been personally arrested and spent a few days in jail, but her family bailed her out. I think she will be there again and may finally decide to change on fear of repeated punishments like that. I actually saw her as a person without a conscience and how do you work with that??? Very difficult for me, particularly with her having a rather innocent, sweet side to her. This is real but not the stronger part of her.

I: Again, it sounds like all these inconsistencies with her.

Debbie: Well, it is true. During her treatment she decided that she wanted to have a tubal ligation. She is pretty sexually active and she may even prostitute, she probably has, and she did not want to get pregnant. The last thing in the world she wanted was to have kids so she decided to have a tubal ligation because she had difficulty taking birth control and she felt that she didn't want any chance of pregnancy so this invoved several visits to the hospital, being with her on the day of the surgery, etc., etc., and I did all that with her so I did get to know her in that way and that was the period of time that I actually worked the closest with her and I felt that in some ways that was a responsible decision on her part but again, with that I also felt it wasn't responsible. I felt is was an easy way out of her just wanting to be promiscuous so I did have some value judgments on that but with that, I went to talk with the psychiatrist and we talked a long time about it and I finally felt with all the things considered, it was probably best for Janet to have a ligation because of the amount of medicaion she was on, it would cause problems if she got pregnant and just given her history, it would probably be a long time before she could handle a child. But I thought she was closing off an option she

shouldn't close off just for expediency. (Continues to read) So, in summary, I wouldn't advocate for her, such as in her living situation (CR) because I often knew that she was in the wrong. The relationship seemed to make little difference to her decisions about behaviour.

I: What was it like, you say here, "seemed to make little difference" knowing that you are working with her and having the sense that she is not committed to...

Debbie: I distanced myself. That's what I did. So, I think that is what happened. I got frustrated and so I distanced. The last two months that she was at the residence she was not doing well but I wasn't seeing her that often because I knew that it would just lead to a discussion of how it wasn't her fault and I just felt that I couldn't so...

I: You just backed off a bit.

Debbie: So I backed off a bit. She just came in and got her medication on time. I did more of that stuff, making sure she got her shots, so at least we had her psychiatric illness covered but... (Continues to read) And I felt the futility of verbal therapy in someone who will seemingly not benefit from it. She did, however, ironically "comply" in the treatment in that she came in regularly for her medication and did keep a good number of appointments with myself and her psychiatrist.

I: Okay.

Debbie: So, that part of the treatment was going well. It was just all the other judgmental stuff that I have that I couldn't get beyond. I think that is why the psychiatrist saw her in a less frustrated way because in terms of her coming and getting her shots, that she did better than she had done in several years. I mean, before that she would use injections and she wouldn't take her pills and also the psychiatrist saw her decision for the tubal ligation as a really good thing so she had a

more positive ally here than me in a way after all.

I: What's it like when you are experiencing these value judgments, like when you are experiencing them with her? What's that like for you?

Debbie: Well, I think it is good actually because I think that that is really the only way you change a little bit in this field because we all have our value judgments. You can't run away from that completely. I mean, the way you are brought up and the way you live is different with everyone and you are going to run into clients who don't have yours but who may have someone else's and for me personally, I think it was a good experience. I think I became a little less judgmental, certainly with respect to the ligation situation and somebody cutting off that option. I really did. In terms of the conscience stuff, even though I don't like it, I see it as separate from psychiatric illness, so it gave me a little bit of objectivity about what is the illness, what is just somebody's values and the importance of separating that a bit in this field and, you know, trying to really deal with the illness part of it and maybe feel good about that, realizing that some of these values are going to be their values whatever. I think the psychiatrist was more successful about that than I was because she always had that focus whereas I had kind of the other. So I think it was a good experience all in all.

I: How would you say that this experience is revealing of how you experience difficulty when you are indeed experiencing difficulty in a psychotherapy situation?

Debbie: Similar. It is very similar. I usually get minor frustration and I end up complaining about the situation and it usually takes awhile until I get some objectivity about what is going on. I tend to distance when I get frustrated with the people. That's a real way I deal with frustration. I'll back off from the person so it is really typical of what I

do. I sort of talk to who I can and then distance from the person who is annoying me. So I don't know if I would do that any differently. Maybe I would get angrier with the person and not keep it so much under wraps. Like, maybe her and my relationship should have been a little rockier than it was and I might have felt better about her.

I: What would you say in terms of the difficulty was specific to this situation?

Debbie: What was specific to this situation?

I: Yeah, specific...unique to this situation in general.

Debbie: Well, I think the fact that she is a client, you have that responsibility to keep on having a relationship to somebody whom you may not like after awhile or may disapprove of things, whereas if it was just a regular person, you probably wouldn't have a whole lot to do with them. The fact that they are a client, you have to keep on in this relationship.

I: I didn't quite ask that right. I meant, specific to this therapy situation.

Debbie: What is the question?

I: What would you say in terms of the different ways you had the experience of difficulty in this therapy situation? What part of it would you say was unique to this particular therapy situation?

Debbie: (Pause) I don't know. I mean, it was unique because it was a different type of case but I have gotten frustrated with other clients. I think the unique part of it was her ability to sort of be a nicer person at some times with me, so I would get hooked into thinking that we could do a little change here, even though that most of the facts showed that you couldn't, whereas with other clients where you can't, you don't see too much glimmer of the hope that you could so you don't get too frustrated. I think with her, her intelligence, humour, you know, something that

looked like, gee, maybe she can get herself together! As I saw all those kinds of good things, she just kept going downhill in terms of her behaviour. I think that was what was unique.

I: What was this exercise like for you?

Debbie: Good. I think the more I think about some of these things with her, the better, because that was a tough case for me. I'm sure there will be others so I don't mind thinking about it and trying to get a handle on what would make it easier for me next time if I had to work with somebody like that again.

Second Follow-Up Interview With Debbie

I: So you did the screening on Janet?

Debbie: Yes.

I: Do you recall your first impression?

Debbie: My first impression of her had been sympathetic because she had been transferred from UCMH and was feeling rejected by them so I felt that I had to reach out and tell her that this was an administrative change and that we were willing to work with her so it was basically sympathetic. It was basically good.

I: How did she react to that?

Debbie: Um, she responded all right. It was sort of, "okay, well I'm glad there was somebody who was going to work with me" so it was a good interchange.

I: Was there a period during therapy...I got the impression from our previous conversataion that there seemed to be a period when you expected some kind of progress, that a useful relationship was developing that would help in the future. Did that in fact occur that was in the initial time period or...

Debbie: Yeah, it wasn't right at the beginning. It was about two months after I started working with her. She ran into a lot of trouble in the sense that her apartment was being broken into. She wasn't feeling really safe at home. She was having problems with men in the community. They were beating her up and taking advantage of her sexually, at least she said so. It was a very vulnerable point and she relied on me a lot and she seemed to need some help...(interruption) and so there was that period of time where she seemed more willing and more dependent on us and willing to follow through on suggestions.

I: What did you actually do during that period?

Debbie: I visited her at home. I helped her plan about whether she was going to stay in her apartment. I placed her at the crisis residence when it looked like she just couldn't stay there anymore. I worked with her family and that was my first disappointment with her. She was in such trouble with the community. I made a lot of effort to place her at the crisis residence. She was there one night and she was breaking the rules. She was lying to them, she was turning around...she basically did not want to comply with their rules and was asked to leave.

I: She didn't respond to the efforts you put into it?

Debbie: Right.

I: How did you respond to that, to her?

Debbie: Well, I was sympathetic. I believed her. Even the problems she had at the crisis residence... she called me and said that they had said that she was doing things she wasn't doing.

I: Initially you believed what she was...

Debbie: Yeah, I believed her and I even went down there and kind of went to bat for her and then in the middle of the treatment meeting on her she became very hostile about...

I: At the crisis residence?

Debbie: Yeah, it was clear that she was lying to me and I really felt foolish. I felt like I had gone out on the limb for somebody who...who was used to lying and was also then did a final psychological thing where I think she almost believed herself so she would really turn the events around and she would do a whole persuasive thing on herself that it was true.

I: Would you say that was like a turning point in your relationship?

Debbie: Yeah.

I: What happened afterwards? What kind of direction did the treatment take after that?

Debbie: There was a more positive period after that. She went to live with another friend. It didn't work out so I placed her at G.M., which is a community residence so then there was some compliance with my treatment plan. There was some obeying of the rules there and motivation to fit in. There was also a lot of lying and bad behaviour and all the stuff that I came to recognize as being part of her. Um, there was an initial bad period when she moved into G.M. and I kind of got through it knowing what she was really like but feeling that she would probably bend a little bit and follow the rules because she didn't have any place to go and then there was about a two month period when she did all right there and I was...

I: What kind of involvement did you have during those two months? What were yo doing with her?

Debbie: I was seeing her pretty often because she was planning on having a tubal ligation. It was her idea. She wanted to have it done. She was very sexually active. She did not want to become pregnant. She arranged the whole thing and I gave her rides to the hospital. I had to take her to get a consent form by the psychiatrist. I was close to her at that point and I felt that she was making an effort at the community residence, so like, treatment was going well.

I: Rather than kind of like...what impressed me now was rather than like there was a period when...it seemed like it was more of a bumpy kind of thing.

Debbie: Yes, up and down. But even the good period at G.M., I was slowly understanding what kind of person she was and I became less invested in her being a success because I knew it wasn't going to be. It was a temporary arrangement that probably that other side of her personality would surface so I started

distancing myself emotionally from her.

I: What was the process of termination? How did that come about?

Debbie: It came about while I was on vacation actually. She was no longer at any of the community residences. She was again in a way...I can't remember. It may have been the time when she was asked to leave the community residence. I was on vacation. Our case manager tried to place her at H.R. and she was very much against that so she wanted nothing else to do with our program. I came back from vacation and she was friendly with me. We discussed that had happened. She didn't want to be associated with H.R. for she was afraid she would be re-hospitalized there and she had chosen to see a private psychiatrist in the community and at that point I felt pretty much in agreement of letting her go because we weren't really doing any treatment as such with her so I felt that it was all right.

I: Was there anything about J that you responded to in terms of her physically? Her dress, gestures, her words, tone of voice, posture? Was there anything during the sessions that triggered anything?

Debbie: It's interesting, well, it's interesting. Often when she would come in and report something to me and I knew she was lying or I knew she had done something that was vaguely illegal or violent I thought she looked really bad. I thought there was something really negative about her appearance and she had very short hair. She would crop it very short so she almost would look like a boy and there was just something down-and-outish about the way she looked. When I approved more of her, sometimes I thought she was attractive. She had sort of a flamboyant way of dressing. She dyed her hair orange. She could look almost...I don't want to use the word...well, sometimes there was almost something diabolical about her appearance to me.

I: You mentioned...I'm kind of unclear what you said before about value judgments. It seemed

like there were two areas you had particular difficulty in the therapy although that seemed to change as you proceeded - the tubal ligation but more that that would be her personal code of ethics, the way she behaved.

Debbie: I think what happened, it brought to the surface my own negative feelings about someone who has that way of operating and that politely I would say, "well, she's at the border of being illegal or having a criminal-type outlook on life". You know, her behaviour borders on the criminal at times and I feel negative about it on the whole, and it brought to the surface that I did feel negative about that kind of behaviour.

I: Did you find it useful at all?

Debbie: I guess useful in the sense that some psychiatric patients...you know, I was constantly trying to judge with Janet is this illness or is this just her particular... is this bad behaviour or criminal behaviour and I began to see that some of it was. Some of it was a lack of conscience, you know, no matter what the source. Once I met her parents I just drew it up to inconsistent parenting and I knew her father and he borders on that kind of criminal role too. That's where it came from. It didn't have anyting to do with psychiatry. It didn't have anything to do with being ill. It had to do with a certain way of operating in the world.

I: It seemed that at some point you made a distinction between the two. As you stated, you differentiated between aspects of her behaviour that were related to her mental illness and then aspects that were...

Debbie: Yeah.

I: Tell me if I understand this. The way I understood the section was that you felt probably that you learned something from, for example, your experience with the tubal ligation that at first you were quite judgmental about it and then you became more accepting.

Debbie: Yeah, that was actually good for me. That was a change of value which I think was good for me because I'd always been very hesitant when to encourage them in any way, to take away the right to reproduce, etc. and with her she really wanted it. She wasn't even asking for our opinions really so it made me more aware of the problems that people that have to be on medication have about pregnancy and that in a lot of cases it is a responsible thing to do, you know, to make plans for good birth control. Actually, her doctor thought that that was her most responsible act, doing that, realizing that she couldn't handle a child and that wouldn't be a bad idea and I finally came to agree with her. I knew her before I did the screening through being the case manager supervisor. She had been opened previously just on case management. Now I knew of her.

I:: So you had an initial impression from that.

Debbie: Yeah.

I: How was it before you ever became involved?

Debbie: It was sympathetic. Also, she had worked temporarily for about a week at an office where I had worked about five years ago and my impression of her was sort of a spacey, sympathetic-like person...who had potential.

# APPENDIX 4

# Appendix 4

## Table I

### Employment Breakdown

| No. of Participants | Type of Setting |
|---|---|
| 5 | Psychiatric Hospital - Outpatient Facility |
| 1 | Psychiatric Hospital - Inpatient Facility |
| 3 | Community Mental Health Facility |
| 1 | Private Practice |

## Table II

### Breakdown of Orientation

| No. of Participants | Type of Orientation |
|---|---|
| 2 | Psychodynamic |
| 1 | Psychodynamic, Family Systems |
| 1 | Cognitive-behavioural, Rogerian |
| 1 | Behavioural,medical |
| 1 | Systems, behavioural |
| 1 | Family, Group |
| 1 | Rogerian, Family |
| 1 | Family Systems/Eric Erickson (Life cycle) |
| 1 | Eclectic |

# APPENDIX 5

Research question, demographic sample sheet and permission slip

## RESEARCH QUESTION

1. Describe a psychotherapeutic situation in which you experienced ongoing difficulty throughout the process.
2. Please give a full account of the different ways in which the difficulties were experienced.

DEMOGRAPHIC INFORMATION

Age_____ Sex_____

Degree_____

Discipline_____

Major(s) 1_____ 2_____

Type of School_____

CLINICAL EXPERIENCE

Total number of years_____

SETTING

Psychiatric Hospital Inpatient_____

Outpatient_____

Rehabilitation Centre_____

Alcohol or Drug Unit_____

University Counselling Centre_____

School_____

Community Mental Health_____

Private Practice_____

Other_____

Area of Specialization_____

Major Orientations_____

I hereby agree to participate in your investigation about experiencing difficulty in psychotherapy. I understand that my contribution is confidential and that I am free to withdraw at any time in the process.